

## Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

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Acitretin



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434337
<b>Guideline Name</b>	Acitretin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:acitretin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of severe psoriasis

**AND**

2 - Prescribed by or in consultation with a dermatologist

**AND**

3 - ONE of the following:

3.1 Failure to a 3-month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records

**OR**

3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

**AND**

4 - ONE of the following:

- Greater than or equal to 10% body surface area involvement
- Palmoplantar, facial, or genital involvement
- Severe scalp psoriasis

Product Name:acitretin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to the requested therapy

**2 . Revision History**

Date	Notes
11/4/2025	Added NV Formulary.

ADHD Agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-518213
<b>Guideline Name</b>	ADHD Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/11/2026
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### 1 . Criteria

<p>Product Name: Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Adzenys XR ODT, Amphetamine ER ODT, Dyanavel XR, Brand Evekeo, generic amphetamine, Cotempla XR ODT, Brand Daytrana, generic methylphenidate patch, Quillivant, Quillichew, Brand Metadate CD, generic methylphenidate cap ER (CD), Brand Ritalin, generic methylphenidate tablets, methylphenidate chew, Brand Methylin, generic methylphenidate solution, methylphenidate ER tab, Brand Concerta, Brand Relexxii, generic methylphenidate ER (OSM), Methylphenidate ER (OSM), Brand Ritalin LA, generic methylphenidate ER (LA), Aptensio XR, generic methylphenidate ER capsules (XR), Jornay PM, Azstarys, methamphetamine, Xelstrym, Brand Zenzedi, generic dextroamphetamine tablets, Brand Procentra, generic dextroamphetamine solution, Brand Dexedrine, dextroamphetamine ER, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Qelbree, Brand Vyvanse, generic lisdexamfetamine, atomoxetine, Brand Intuniv, generic guanfacine ER, clonidine ER 0.1 mg, Onyda XR</p>	
Diagnosis	Patients over 18 years of age

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Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Both of the following:</p> <ul style="list-style-type: none"> <li>• Patient has a diagnosis of ADD/ADHD (Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder)</li> <li>• Other treatable causes of ADD/ADHD have been ruled out</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>1.2 Patient has another Food and Drug Administration (FDA) approved diagnosis</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Adzenys XR ODT, Amphetamine ER ODT, Dyanavel XR, Brand Evekeo, generic amphetamine, Cotempla XR ODT, Brand Daytrana, generic methylphenidate patch, Quillivant, Quillichew, Brand Metadate CD, generic methylphenidate cap ER (CD), Brand Ritalin, generic methylphenidate tablets, methylphenidate chew, Brand Methylin, generic methylphenidate solution, methylphenidate ER tab, Brand Concerta, Brand Relexxii, generic methylphenidate ER (OSM), Methylphenidate ER (OSM), Brand Ritalin LA, generic methylphenidate ER (LA), Aptensio XR, generic methylphenidate ER capsules (XR), Jornay PM, Azstarys, methamphetamine, Xelstrym, Brand Zenzedi, generic dextroamphetamine tablets, Brand Procentra, generic dextroamphetamine solution, Brand Dexedrine, dextroamphetamine ER, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Qelbree, Brand Vyvanse, generic lisdexamfetamine, atomoxetine, Brand Intuniv, generic guanfacine ER, clonidine ER 0.1 mg, Onyda XR

Diagnosis	Patients less than or equal to 18 years of age
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Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <ul style="list-style-type: none"> <li>• The request is for a short-acting stimulant and the patient is at least 3 years of age</li> <li>• For any other request, the patient is at least 6 years of age</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p>2.1 If prescribed by a psychiatrist, the patient has an International Classification of Diseases (ICD) code for ADD (Attention Deficit Disorder) with or without hyperactivity</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 BOTH of the following:</p> <p>2.2.1 One of the following:</p> <p>2.2.1.1 Both of the following:</p> <ul style="list-style-type: none"> <li>• Patient has a diagnosis of ADD/ADHD (Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder)</li> <li>• Other treatable causes of ADD/ADHD have been ruled out</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2.1.2 Patient has another Food and Drug Administration (FDA) approved diagnosis</p> <p style="text-align: center;"><b>AND</b></p> <p>2.2.2 An initial evaluation or regular examination has been done within the past 12 months with the treating prescriber</p>	

**AND**

**3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/10/2026	Updated criteria for patient's less than or equal to 18 years of age.

Alzheimer’s Disease Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-504217
<b>Guideline Name</b>	Alzheimer’s Disease Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Aduhelm	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:</p> <p>1.1 Based on the National Institute on Aging and the Alzheimer’s Association (NIA-AA) criteria, ONE of the following:</p>	

- Diagnosis of mild cognitive impairment due to Alzheimer's disease
- Diagnosis of probable Alzheimer's disease dementia

**AND**

**1.2 ALL of the following:**

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Repeatable Battery for the Assessment of Neuropsychological (RBANS) score 85 or less
- Mini-Mental State Examination score of 24-30
- Montreal Cognitive Assessment (MoCA) of 17 or above

**AND**

**2 - Documentation of beta-amyloid protein disposition, as evidenced by ONE of the following:**

**2.1 Positive amyloid positron emission tomography (PET) scan**

**OR**

**2.2 BOTH of the following:**

- Attestation that the patient does not have access to amyloid PET scanning
- Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., AB42 level, AB42:AB40 ratio)

**AND**

**3 - ALL of the following:**

- Patient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less)
- Patient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment
- Patient had no history of relevant brain hemorrhage, bleeding disorder, and cerebrovascular abnormalities in last six months

**AND**

**4** - A baseline brain MRI has been completed within 12 months prior to initiating treatment to rule out other causes (e.g., stroke, small vessel disease, tumor)

**AND**

**5** - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA) (ARIA with edema [ARIA-E] and ARIA with hemosiderin deposition [ARIA-H]) and recipient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting

**AND**

**6** - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist, or other expert in the disease state

Product Name: Aduhelm

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Submission of medical records (e.g., chart notes, laboratory values) documenting benefit from therapy as defined by BOTH of the following:

**1.1** Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, ONE of the following:

- Patient continues to have a diagnosis of mild cognitive impairment due to Alzheimer's disease
- Patient continues to have a diagnosis of probable Alzheimer's disease dementia

**AND**

**1.2 ALL of the following:**

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Repeatable Battery for the Assessment of Neuropsychological (RBANS) score 85 or less
- Mini-Mental State Examination score of 24-30

**AND**

**2 - Patient has a follow-up brain MRI that has been completed after the initiation of therapy to show ONE of the following:**

**2.1 BOTH of the following:**

- Less than 10 new incident microhemorrhages
- 2 or less focal areas of superficial siderosis

**OR**

**2.2 If 10 or more new incident microhemorrhages or greater than 2 focal areas of superficial siderosis are present, then BOTH of the following:**

- Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances)
- Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H)

**AND**

**3 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist**

Product Name:Leqembi, Leqembi IQLIK	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of ONE of the following:

- Mild cognitive impairment due to Alzheimer's disease (AD)
- Mild dementia due to AD

**AND**

**2** - ALL of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 to 1
- Memory Box score at least 0.5
- Mini-Mental State Examination (MMSE) score of 22-30
- Objective evidence of cognitive impairment at screening
- PET scan or CSF assessment of amyloid beta (1-42) is positive for amyloid beta plaque

**AND**

**3** - Prescriber attests that other conditions causing similar symptoms have been ruled out (e.g., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus)

**AND**

**4** - Prescribed by a neurologist, geriatrician, geriatric psychiatrist, or other expert in the treatment of AD

**AND**

**5** - Patient does not have risk factors for intracerebral hemorrhage (e.g., prior cerebral hemorrhage > 1 cm in greatest diameter, more than 4 microhemorrhages, superficial siderosis, evidence of vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel, or white matter disease)

**AND**

**6** - Patient has NOT had a stroke, TIA, or seizure in the last 12 months

**AND**

**7** - Patient has NOT demonstrated clinically significant and unstable psychiatric illness in the last six months

**AND**

**8** - Patient does NOT have a history of alcohol or substance abuse within the last 12 months

**AND**

**9** - Patient is NOT currently taking an anticoagulant or antiplatelet agent (with the exception of aspirin 325 mg/day or less)

**AND**

**10** - Brain MRI has been obtained within 12 months prior to treatment initiation

**AND**

**11** - Baseline disease severity has been assessed using an objective measure/tool (e.g., MMSE, AD Assessment Scale-Cognitive Subscale [ADAS-Cog-13], AD Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating Sum of Boxes [CDR-SB])

Product Name:Leqembi, Leqembi IQLIK	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient continues to meet initial authorization criteria

**AND**

2 - Scoring on an objective measure/tool demonstrates improvement, stability, or slowing in cognitive and/or functional impairment (e.g., AD Assessment Scale-Cognitive Subscale [ADAS-Cog-13], AD Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Mini-Mental State Examination [MMSE], Clinical Dementia Rating Sum of Boxes [CDR-SB])

**AND**

3 - Patient has not progressed to moderate or severe Alzheimer's disease (AD)

**AND**

4 - Patient has not experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions)

**AND**

5 - Patient has undergone MRI prior to the 5th, 7th, and 14th infusions to monitor for ARIA-E or ARIA-H

Product Name:Kisunla	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1** - Patient has a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild Alzheimer's dementia as evidenced by BOTH of the following:

- MMSE (Mini-Mental State Examination) score 20 to 28
- PET scan or CSF assessment of amyloid beta (1-42) is positive for amyloid beta plaque

**AND**

**2** - Prescriber has assessed baseline disease severity utilizing an objective measure/tool (e.g., MMSE, Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-13], Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB])

**AND**

**3** - Other conditions mimicking, but of non-Alzheimer's dementia etiology, have been ruled out (e.g., vascular dementia, dementia with Lewy bodies [DLB], frontotemporal dementia [FTD], normal pressure hydrocephalus)

**AND**

**4** - A baseline MRI has been obtained prior to initiating treatment with Kisunla

**AND**

**5** - Prescriber attests that MRI will be repeated prior to the 2nd, 3rd, 4th, and 7th infusions

**AND**

**6** - Patient does not have history of alcohol or substance abuse within the past 2 years

**AND**

**7** - Medication will NOT be used concurrently with other anti-amyloid immunotherapies (e.g., Leqembi)

**AND**

**8** - Prescribed by a neurologist, geriatrician, geriatric psychiatrist, or other specialist with advanced knowledge in treating AD

Product Name:Kisunla	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a diagnosis of mild cognitive impairment (MCI) due to Alzheimer’s disease (AD) or mild Alzheimer’s dementia as evidenced by BOTH of the following:</p> <ul style="list-style-type: none"> <li>• MMSE (Mini-Mental State Examination) score 20 to 28</li> <li>• PET scan or CSF assessment of amyloid beta (1-42) is positive for amyloid beta plaque</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescriber has assessed baseline disease severity utilizing an objective measure/tool (e.g., MMSE, Alzheimer’s Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-13], Alzheimer’s Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB])</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Other conditions mimicking, but of non-Alzheimer’s dementia etiology, have been ruled out (e.g., vascular dementia, dementia with Lewy bodies [DLB], frontotemporal dementia [FTD], normal pressure hydrocephalus)</p> <p style="text-align: center;"><b>AND</b></p>	

**4** - Prescriber attests that MRI will be repeated prior to the 2nd, 3rd, 4th, and 7th infusions

**AND**

**5** - Patient does not have history of alcohol or substance abuse within the past 2 years

**AND**

**6** - Medication will NOT be used concurrently with other anti-amyloid immunotherapies (e.g., Leqembi)

**AND**

**7** - Prescribed by a neurologist, geriatrician, geriatric psychiatrist, or other specialist with advanced knowledge in treating AD

**AND**

**8** - Scoring on an objective measure/tool (e.g., ADAS-Cog 13; ADCS-ADL-MCI; MMSE; CDR-SB) demonstrates improvement, stability, or slowing in cognitive and/or functional impairment

**AND**

**9** - Patient has NOT progressed to moderate or severe AD

**AND**

**10** - Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions)

**AND**

**11** - Prescriber attests that stopping of Kisunla dosing will be considered when amyloid plaques are reduced to minimal levels on amyloid PET imaging

## 2 . Revision History

Date	Notes
1/20/2026	Added Kisunla

Amvuttra



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-423407
<b>Guideline Name</b>	Amvuttra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Amvuttra	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient will receive supplementation with vitamin A as the recommended daily allowance during Amvuttra therapy

**AND**

**3** - Amvuttra will NOT be used in combination with other transthyretin (TTR) reducing agents (e.g., inotersen [Tegsedi], tafamidis [Vyndamax, Vyndaqel], patisiran [Onpattro])

**AND**

**4** - Both of the following:

**4.1** Patient has a definitive diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis (formerly known as familial amyloid polyneuropathy (FAP))

**AND**

**4.2** Diagnosis is confirmed by amyloid deposition on tissue biopsy and identification of a pathogenic TTR variant using molecular genetic testing

**AND**

**5** - Polyneuropathy is demonstrated by AT LEAST 2 of the following:

- Subjective patient symptoms are suggestive of neuropathy
- Abnormal nerve conduction studies are consistent with polyneuropathy
- Abnormal neurological examination is suggestive of neuropathy

**AND**

**6** - Both of the following:

- Patient's peripheral neuropathy is attributed to hATTR
- Other causes of neuropathy have been excluded

**AND**

**7** - Baseline strength and weakness has been documented using an objective clinical measuring tool (e.g., Medical Research Council [MRC] muscle strength)

**AND**

**8** - Patient has not had an orthotopic liver transplant (OLT)

**AND**

**9** - Quantity does not exceed one syringe every three months

Product Name:Amvuttra	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Patient continues to meet the initial criteria

**AND**

**2** - Absence of unacceptable toxicity from the drug (e.g. ocular symptoms related to hypovitaminosis A, etc.)

**AND**

**3** - Patient has experienced disease response compared to pre-treatment baseline as evidenced by ONE of the following:

- Stabilization or improvement in signs and symptoms of neuropathy
- Stabilization or improvement in Medical Research Council (MRC) Scale for muscle strength

## 2 . Revision History

Date	Notes
10/23/2025	New

Andembry



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-504190
<b>Guideline Name</b>	Andembry
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Andembry	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

**1.1** C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

**OR**

**1.2** HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiotensin-converting enzyme 1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosaminase 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

**AND**

**2** - Prescribed for the prophylaxis of HAE attacks

**AND**

**3** - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)

**AND**

**4** - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Andembry

**AND**

**5** - Prescribed by ONE of the following:

- Immunologist
- Allergist

**AND**

**6** - ONE of the following:

**6.1** Failure to Haegarda confirmed by claims history or submitted medical records

**OR**

**6.2** History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

**OR**

**6.3** Patient is currently on Andembry therapy confirmed by claims history or submitted medical records

Product Name:Andembry	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Andembry therapy</p>	

**AND**

**3** - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Andembry therapy

**AND**

**2** - Prescribed for the prophylaxis of HAE attacks

**AND**

**4** - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)

**AND**

**5** - Prescribed by ONE of the following:

- Immunologist
- Allergist

## 2 . Revision History

Date	Notes
1/15/2026	New Program.

Anthelmintics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434339
<b>Guideline Name</b>	Anthelmintics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Generic albendazole	
Approval Length	*Approve for 1 month, **Approve for 6 months, ***Approve for 12 months
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of ONE of the following\*:

- Enterobius vermicularis (pinworm)
- Ascariasis (roundworm)
- Toxocariasis (roundworm)
- Trichinellosis
- Trichuriasis (whipworm)
- Capillariasis
- Baylisascaris
- Clonorchiasis (liver flukes)
- Gnathostomiasis
- Strongyloidiasis
- Loiasis
- Opisthorchiasis
- Anisakiasis

**OR**

2 - Diagnosis of ONE of the following\*\*:

- Taeniasis or Cysticercosis/Neurocysticercosis
- Hydatid Disease [Echinococcosis (Tapeworm)]
- Ancylostoma/Necatoriasis (Hookworm)

**OR**

3 - Diagnosis of microsporidiosis not caused by Enterocytozoon bienersi or Vittaforma corneae\*\*\*

Product Name: Emverm	
Approval Length	*Approve for 1 month, **Approve for 6 months
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - Diagnosis of ONE of the following\*:

- Enterobius vermicularis (pinworm)
- Ancylostoma/Necatoriasis (Hookworm)
- Ascariasis (roundworm)
- Toxocariasis (roundworm)
- Trichinellosis
- Trichuriasis (whipworm)
- Capillariasis
- Baylisascaris

**OR**

2 - Diagnosis of hydatid Disease [Echinococcosis (Tapeworm)]\*\*

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary - LKC

Anti-Fungal Agents



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-458407
<b>Guideline Name</b>	Anti-Fungal Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Vivjoa	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of recurrent vulvovaginal candidiasis (VVC) with greater than or equal to 3 episodes of VVC in a 12-month period</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)

**AND**

**3** - Patient does NOT have hypersensitivity to any component of the product

**AND**

**4** - Patient is NOT pregnant

**AND**

**5** - Patient is NOT lactating

**AND**

**6** - Patient has tried and failed or has contraindication or intolerance to maintenance antifungal therapy with oral fluconazole for six months

## 2 . Revision History

Date	Notes
12/8/2025	Removed all criteria except for Vivjoa.

Anti-Hepatitis Agents



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-423190
<b>Guideline Name</b>	Anti-Hepatitis Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Epclusa, Sofosbuvir/velpatasvir	
Approval Length	Reference criteria section for approval length: approval length is 12 weeks if * notated; approval length is 24 weeks if ** notated
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient is not receiving the requested medication in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

**AND**

**3** - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

**AND**

**4** - The patient meets one of the following:

**4.1** If genotype 1, 2, 3, 4, 5, or 6 and without decompensated liver disease, both of the following:\*

- The requested medication is being used alone
- The request is FDA (Food and Drug Administration) approved for patient weight and age

**OR**

**4.2** If genotype 1, 2, 3, 4, 5, or 6 and with decompensated liver disease, both of the following:\*\*

- The requested medication is being used in combination with ribavirin
- The request is FDA approved for patient weight and age

**OR**

**4.3** If genotype 1, 2, 3, 4, 5, or 6 and with ribavirin intolerance/ineligible or prior Sovaldi (sofosbuvir) or NS5A-based treatment failure, both of the following:\*\*

**4.3.1** The patient has decompensated liver disease

**AND**

**4.3.2** One of the following:

**4.3.2.1** The patient is ribavirin intolerant or ineligible

**OR**

**4.3.2.2** Both of the following:

- The patient has had prior failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) to Sovaldi or NS5A-based treatment
- The requested medication is being used in combination with ribavirin

Product Name: Harvoni, Ledipasvir/sofosbuvir	
Approval Length	Reference criteria section for approval length: approval length is 8 weeks if * notated; approval length is 12 weeks if ** notated; approval length is 24 weeks if *** notated
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient is not receiving the requested medication in combination with another HCV (Hepatitis C Virus) direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The requested medication is prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Hepatologist</li> <li>• Gastroenterologist</li> <li>• Infectious Disease Specialist</li> <li>• HIV Specialist (certified through the American Academy of HIV Medicine)</li> </ul>	

**AND**

**3** - The patient meets one of the following:

**3.1** If genotype 1, and treatment naïve, without cirrhosis and pre-treatment HCV ribonucleic acid (RNA) is less than 6 million IU/mL (international units per milliliter), both of the following:\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records confirming pre-treatment HCV RNA less than 6 million IU/mL

**OR**

**3.2** If genotype 1, and treatment naïve, without cirrhosis and pre-treatment HCV RNA is greater than or equal to 6 million IU/mL, both of the following:\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records confirming pre-treatment HCV RNA greater than or equal to 6 million IU/mL

**OR**

**3.3** If genotype 1, and treatment naïve, with compensated cirrhosis, all of the following:\*\*

**3.3.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1

**AND**

**3.3.2** Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has cirrhosis

**AND**

**3.3.3** The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**OR**

**3.4** If genotype 1, and treatment experienced, without cirrhosis, both of the following:\*\*

**3.4.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1

**AND**

**3.4.2** One of the following:

**3.4.2.1** The patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] plus peginterferon plus ribavirin

**OR**

**3.4.2.2** Both of the following:

- The patient has experienced treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) except in combination with Olysio (simeprevir)
- The medication is used in combination with ribavirin

**OR**

**3.5** If genotype 1, and ribavirin eligible, treatment experienced, with compensated cirrhosis, all of the following:\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has cirrhosis
- The patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] plus peginterferon plus ribavirin
- The requested medication is used in combination with ribavirin
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**OR**

**3.6** If genotype 1, and ribavirin ineligible, treatment experienced, with compensated cirrhosis, all of the following:\*\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has cirrhosis
- The patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] plus peginterferon plus ribavirin
- The patient is ribavirin ineligible
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**OR**

**3.7** If genotype 1, 4, 5 or 6 and with decompensated cirrhosis or post-liver transplant, all of the following:\*\*

**3.7.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 4, 5 or 6

**AND**

**3.7.2** One of the following:

**3.7.2.1** Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has decompensated cirrhosis (e.g., Child-Pugh class B or C)

**OR**

**3.7.2.2** Both of the following:

- The patient is a liver transplant recipient
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**AND**

**3.7.3** The medication is used in combination with ribavirin

**OR**

**3.8** If genotype 1,4, 5, or 6 and with decompensated cirrhosis, ribavirin ineligible or prior failure of Sovaldi or NS5A based regimen, all of the following:\*\*\*

**3.8.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 4, 5 or 6

**AND**

**3.8.2** Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has decompensated cirrhosis (e.g., Child-Pugh class B or C)

**AND**

**3.8.3** One of the following:

**3.8.3.1** The patient is ribavirin ineligible

**OR**

**3.8.3.2** Both of the following:

- The patient has experienced treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) or an NS5A inhibitor [e.g., Daklinza (daclatasvir)]
- The medication is used in combination with ribavirin

**OR**

**3.9** If genotype 4, and treatment naïve or treatment experienced (peginterferon plus ribavirin), both of the following:\*\*

**3.9.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 4

**AND**

**3.9.2** One of the following:

**3.9.2.1** The patient is treatment naïve

**OR**

**3.9.2.2** One of the following:

**3.9.2.2.1** The patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin and is without cirrhosis

**OR**

**3.9.2.2.2** Both of the following:

- The patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin and has compensated cirrhosis (Child-Pugh class A)
- The medication is used in combination with ribavirin

**OR**

**3.10** If genotype 5 or 6, and treatment naïve or treatment experienced (peginterferon plus ribavirin), both of the following:\*\*

**3.10.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 5 or 6

**AND**

**3.10.2** One of the following:

- The patient is treatment naïve
- The patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin

Product Name:Mavyret	
Approval Length	Reference criteria section for approval length: approval length is 8 weeks if * notated; approval length is 12 weeks if ** notated; approval length is 16 weeks if *** notated
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient is not receiving the requested medication in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The requested medication is prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Hepatologist</li> <li>• Gastroenterologist</li> <li>• Infectious Disease Specialist</li> <li>• HIV Specialist (certified through the American Academy of HIV Medicine)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient meets one of the following:</p> <p><b>3.1</b> If genotype 1, 2, 3, 4, 5, or 6, and treatment naïve without cirrhosis, both of the following:**</p> <ul style="list-style-type: none"> <li>• Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV</li> <li>• The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>3.2</b> If genotype 1, 2, 3, 4, 5, or 6, and treatment naïve, with compensated cirrhosis, both of the following:*</p> <ul style="list-style-type: none"> <li>• Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV</li> </ul>	

- The patient has compensated cirrhosis (Child-Pugh class A)

**OR**

**3.3** If genotype 1, and treatment experienced (prior failure to an NS3/4A protease inhibitor), without decompensated cirrhosis, all of the following:\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- The patient has experienced failure with a previous treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]
- The patient has had no previous treatment experience with a treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**OR**

**3.4** If genotype 1, and treatment experienced (prior failure to an NS5A inhibitor), without decompensated cirrhosis, all of the following:\*\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- The patient has experienced failure with a previous treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]
- The patient is without decompensated cirrhosis (Child-Pugh class B or C)

**OR**

**3.5** If genotype 3, and treatment experienced (interferon or Sovaldi based regimen), without decompensated cirrhosis, all of the following:\*\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 3
- The patient has experienced failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor [e.g., Daklinza (daclatasvir)]

- The patient is without decompensated cirrhosis (Child-Pugh class B or C)

**OR**

**3.6** If genotype 1, 2, 4, 5, or 6, and treatment experienced (interferon or Sovaldi based regimen), without cirrhosis, all of the following:\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 2, 4, 5 or 6
- The patient has experienced failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor [e.g., Daklinza (daclatasvir)]

**OR**

**3.7** If genotype 1, 2, 4, 5, or 6, and treatment experienced (interferon or Sovaldi based regimen), with compensated cirrhosis, all of the following:\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 2, 4, 5 or 6
- The patient has experienced failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza (daclatasvir)]
- The patient has compensated cirrhosis (e.g., Child-Pugh class A)

Product Name: Sovaldi	
Approval Length	Reference criteria section for approval length: approval length is 12 weeks if * notated; approval length is 24 weeks if ** notated
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The requested medication is prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Hepatologist</li> </ul>	

- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

**AND**

**2** - The patient meets one of the following:

**2.1** If genotype 1 or 4 and without decompensated liver disease, all of the following:\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) genotype 1 or 4
- The requested medication is used in combination with peginterferon alfa and ribavirin
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)
- The patient has not experienced failure with a previous treatment regimen that includes Sovaldi

**OR**

**2.2** If genotype 3, and without decompensated liver disease, all of the following:\*\*

**2.2.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) genotype 3

**AND**

**2.2.2** One of the following:

- Patient is 12 years of age or older
- If patient is less than 12 years of age, the patient weighs at least 35 kg (kilograms)

**AND**

**2.2.3** The requested medication is used in combination with ribavirin

**AND**

**2.2.4** The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**AND**

**2.2.5** The patient has not experienced failure with a previous treatment regimen that includes Sovaldi

**OR**

**2.3** If genotype 2, and without decompensated cirrhosis, all of the following:\*

**2.3.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) genotype 2

**AND**

**2.3.2** One of the following:

- Patient is 12 years of age or older
- If patient is less than 12 years of age, the patient weighs at least 35 kg (kilograms)

**AND**

**2.3.3** The medication is used in combination with ribavirin

**AND**

**2.3.4** The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

**AND**

**2.3.5** The patient has not experienced failure with a previous treatment regimen that includes Sovaldi

Product Name:Vosevi	
Approval Length	12 Week(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is not receiving the requested medication in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The requested medication is prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Hepatologist</li> <li>• Gastroenterologist</li> <li>• Infectious Disease Specialist</li> <li>• HIV Specialist (certified through the American Academy of HIV Medicine)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The patient meets one of the following:</p> <p><b>4.1</b> If genotype 1, 2, 3, 4, 5, or 6, and without decompensated cirrhosis, prior relapse to NS5A based regimen, all of the following:</p> <ul style="list-style-type: none"> <li>• Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV</li> <li>• The patient is a previous relapse to an NS5A based regimen [(e.g., Daklinza (daclatasvir), Epclusa (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Technivie (ombitasvir/paritaprevir/ritonavir), Viekira (ombitasvir/paritaprevir/ritonavir/dasabuvir), Zepatier (elbasvir/grazoprevir)]</li> <li>• Submission of medical records (e.g., chart notes or laboratory values) confirming normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)</li> </ul>	

**OR**

**4.2** If genotype 1a, without decompensated cirrhosis, prior relapse to sofosbuvir based regimen without an NS5A inhibitor, both of the following:

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1a
- The patient is a previous relapser to a sofosbuvir based regimen without an NS5A inhibitor

**OR**

**4.3** If genotype 3 and without decompensated cirrhosis, prior relapse to sofosbuvir based regimen without an NS5A inhibitor, both of the following:

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 3
- The patient is a previous relapser to a sofosbuvir based regimen without an NS5A inhibitor

Product Name: Zepatier	
Approval Length	Reference criteria section for approval length: approval length is 12 weeks if * notated; approval length is 16 weeks if ** notated
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh class B or C)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is not receiving the requested medication in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]</p>	

**AND**

**3** - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

**AND**

**4** - The patient meets one of the following:

**4.1** If genotype 1a, and treatment naïve, or Peg-IFN/RBV experienced, or Peg-IFN/RBV/protease inhibitor experienced, without NS5A polymorphism, all of the following:\*\*

**4.1.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1a

**AND**

**4.1.2** One of the following:

- The patient is treatment naïve
- The patient has had prior failure to peginterferon alfa plus ribavirin treatment
- The patient has had prior failure to treatment with peginterferon alfa plus ribavirin plus an HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)

**AND**

**4.1.3** Both of the following:

- The patient has been tested for the presence of NS5A resistance associated polymorphisms
- The patient has baseline NS5A resistance associated polymorphisms (e.g., polymorphisms at amino acid positions 28, 30, 31, or 93)

**AND**

**4.1.4** The requested medication is used in combination with ribavirin

**OR**

**4.2** If genotype 1b, and treatment naïve, or Peg-IFN/RBV experienced, or Peg-IFN/RBV/protease inhibitor experience, both of the following:\*

**4.2.1** Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1b

**AND**

**4.2.2** One of the following:

**4.2.2.1** The patient is treatment naïve

**OR**

**4.2.2.2** The patient has had prior failure to peginterferon alfa plus ribavirin treatment

**OR**

**4.2.2.3** Both of the following:

- The patient has had prior failure to treatment with peginterferon alfa plus ribavirin plus an HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir or telaprevir)
- The requested medication is used in combination with ribavirin

**OR**

**4.3** If Genotype 4, and treatment naïve, submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 4\*

**OR**

**4.4** If genotype 4, and Peg-IFN/RBV experienced, all of the following:\*\*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 4
- The patient has had prior failure to peginterferon alfa plus ribavirin
- The requested medication is used in combination with ribavirin

## 2 . Revision History

Date	Notes
10/23/2025	New guideline

Anti-lipidemic Agents - PCSK9 Inhibitors



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-504220
<b>Guideline Name</b>	Anti-lipidemic Agents - PCSK9 Inhibitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Praluent, Repatha	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has an FDA (Food and Drug Administration)-approved diagnosis and meets labeled age requirement</p>	

**AND**

**2** - The requested medication was prescribed by, or in consultation with, a cardiologist or lipid specialist

**AND**

**3** - The requested medication will be used as an adjunct to a low-fat diet and exercise

**AND**

**4** - One of the following:

**4.1** Both of the following:

**4.1.1** The patient has had an inadequate response to high intensity statin therapy defined as all of the following:

- The patient has received therapy with at least 40 mg (milligram) of atorvastatin or at least 20 mg of rosuvastatin for at least the past three months
- The patient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past two weeks or the patient has a contraindication to ezetimibe therapy
- The low-density lipoprotein cholesterol (LDL-C) after therapy for at least the past three months was either greater than or equal to 100 mg/dL (milligrams/deciliter) for familial hypercholesterolemia or greater than or equal to 70 mg/dL for clinical atherosclerotic cardiovascular disease

**AND**

**4.1.2** The statin therapy will be continued with the requested therapy

**OR**

**4.2** Both of the following:

**4.2.1** The patient has had an inadequate response to moderate intensity statin therapy defined as all of the following:

**4.2.1.1** The patient has an intolerance or contraindication to high intensity statin therapy

**AND**

**4.2.1.2** The patient has received therapy with one of the following for at least the past 3 months:

- atorvastatin 10 to 20 mg
- rosuvastatin 5 to 10 mg
- simvastatin greater than 20 mg
- pravastatin greater than 40 mg
- lovastatin 40 mg
- fluvastatin XL 80 mg
- fluvastatin 40 mg twice daily
- pitavastatin greater than 2 mg

**AND**

**4.2.1.3** The patient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past two weeks or the patient has a contraindication to ezetimibe therapy

**AND**

**4.2.1.4** The LDL-C after therapy for at least the past three months was either greater than or equal to 100 mg/dL for familial hypercholesterolemia or greater than or equal to 70 mg/dL for clinical atherosclerotic cardiovascular disease

**AND**

**4.2.2** The statin therapy will be continued with the requested therapy

**OR**

**4.3** Documentation that the patient experienced an adverse reaction to at least two statins (please document adverse reaction)

**OR**

**4.4** Documentation that the patient has a labeled contraindication to all statins (please document contraindication)

Product Name:Praluent, Repatha	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has been adherent with the requested therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient has been adherent with statin therapy, has experienced an adverse reaction to at least two statins or the patient has a labeled contraindication to statin therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The patient is continuing a low-fat diet and exercise regimen</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - The patient has achieved a reduction in LDL-C (low-density lipoprotein cholesterol) level</p>	

**2 . Revision History**

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

1/20/2026	Updated LDL requirements and consolidated criteria. Added free text box prompts for adverse reaction and contraindication in initial auth.
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Anti-Migraine Agents



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-504218
<b>Guideline Name</b>	Anti-Migraine Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name: Brand Frova, generic frovatriptan, brand Relpax, generic eletriptan, brand Maxalt, brand Maxalt- MLT, generic rizatriptan, generic rizatriptan ODT, brand Imitrex tab/inj, generic sumatriptan tab/nasal/inj, brand Treximet, generic sumatriptan/naproxen, almotriptan, naratriptan, Zembrace, brand Zomig tab/nasal, generic zolmitriptan tab/nasal/ODT, Tosymra, Onzetra Xsail, Reyvow	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 The patient’s current medication history documents the use of prophylactic medications</p>	

for migraine headache (e.g. beta-blockers, tricyclic antidepressants, anticonvulsants, selective serotonin reuptake Inhibitors (SSRIs) and/or calcium channel blockers)

**OR**

**1.2** Prescriber agrees to initiating prophylactic medications for migraine headache (e.g. beta-blockers, tricyclic antidepressants, anticonvulsants, selective serotonin reuptake Inhibitors (SSRIs) and/or calcium channel blockers)

**OR**

**1.3** Prescriber is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required

**AND**

**2** - Patient does NOT have ischemic heart disease

**AND**

**3** - If the request is for a sumatriptan, rizatriptan, or a zolmitriptan product, the patient's current medication history does not have monoamine oxidase (MAO) inhibitors

**AND**

**4** - If the request is for Maxalt (rizatriptan) 10mg or Maxalt-MLT (rizatriptan ODT) 10mg, the patient's current medication history does not indicate the use of propranolol

**AND**

**5** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Aimovig, Ajovy, Emgality 120mg, Qulipta, Vyepti

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 ALL of the following:</p> <p>1.1.1 Patient has a diagnosis of episodic migraines</p> <p style="text-align: center;"><b>AND</b></p> <p>1.1.2 Patient has 4 to 14 migraine days per month, but not more than 14 headache days per month</p> <p style="text-align: center;"><b>AND</b></p> <p>1.1.3 ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patient is 18 years of age or older</li> <li>• If the request is for Ajovy, the patient is six years of age or older and weighs 45 kg or more</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>1.2 ALL of the following:</p> <p>1.2.1 Patient has a diagnosis of chronic migraines</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.2 Patient has at least 15 headache days per month, of which at least eight must be migraine days for at least three months</p>	

**AND**

**1.2.3** Patient has been considered for medication overuse headache (MOH) and potentially offending medication(s) have been discontinued

**AND**

**1.2.4** Patient is 18 years of age or older

**AND**

**2** - Patient has a documented history of failure (after at least a two-month trial) or an intolerance/contraindication to at least one medication from TWO of the following categories:

- Elavil (amitriptyline) or Effexor (venlafaxine)
- Depakote/Depakote ER (divalproex) or Topamax (topiramate)
- One of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

**AND**

**3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Aimovig, Ajoovy, Emgality 120mg, Qulipta, Vyepti	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a documented positive response to the CGRP (calcitonin gene-related peptide) therapy, demonstrated by a reduction in headache frequency and/or intensity</p>	

**AND**

**2** - Patient has had a decrease in use of acute migraine medications (e.g., NSAIDs, triptans) since the start of CGRP therapy

**AND**

**3** - If the patient is using the requested medication for prevention of chronic migraine, the patient continues to be monitored for medication overuse headache

Product Name:Nurtec ODT	
Diagnosis	Episodic Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has a diagnosis of episodic migraines, having 4 to 14 migraine days per month but not more than 18 headache days per month</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - TWO of the following:</p> <p><b>3.1</b> One of the following:</p> <ul style="list-style-type: none"> <li>• Patient has a documented history of failure (after at least a two-month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)</li> </ul>	

- Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

**OR**

**3.2** One of the following:

- Patient has a documented history of failure (after at least a two-month trial) or intolerance to Depakote/Depakote ER (divalproex) or Topamax (topiramate)
- Patient has a contraindication to both Depakote/Depakote ER (divalproex) or Topamax (topiramate)

**OR**

**3.3** Patient has a history of failure (after at least a two-month trial) or intolerance to one of the following beta blockers:

- Atenolol
- Propranolol
- Nadolol
- Timolol
- Metoprolol

**AND**

**4** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Nurtec ODT

Diagnosis	Episodic Migraine
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Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Patient has a documented positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

**AND**

**2** - Patient has had a decrease in use of acute migraine medications (e.g., NSAIDs, triptans) since the start of therapy

Product Name:Nurtec ODT, Ubrelvy, Zavzpret	
Diagnosis	Acute Migraines
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Patient has a diagnosis of acute migraine with or without aura

**AND**

**2** - Patient is 18 years of age or older

**AND**

**3** - ONE of the following:

- For Zavzpret requests, the prescribed dose will not exceed one spray in 24 hours
- For all other requests, the prescribed dose will not exceed two doses per migraine

**AND**

**4** - Requested medication is treating no more than eight migraine episodes per 30 days

**AND**

**5** - Patient has had at least one trial and failure of a triptan agent

**AND**

**6** - The medication is prescribed by or in consultation with a neurologist or a pain specialist

**AND**

**7** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Nurtec ODT, Ubrelvy, Zavzpret	
Diagnosis	Acute Migraines
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a documented positive response to the CGRP (calcitonin gene-related peptide) therapy</p> <p><b>AND</b></p> <p><b>2</b> - The medication is prescribed by or in consultation with a neurologist or a pain specialist</p>	

Product Name:Emgality 100mg	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient has a diagnosis of episodic cluster headache

**AND**

2 - Patient has experienced at least two cluster periods lasting from seven days to 365 days, separated by pain-free periods lasting at least three months

**AND**

3 - Patient is 18 years of age or older

**AND**

4 - The medication is prescribed by or in consultation with a neurologist or a pain specialist

**AND**

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Emgality 100mg

Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - Patient has documented positive response to Emgality therapy, demonstrated by a reduction in headache frequency and/or intensity

**AND**

**2** - The medication is prescribed by or in consultation with a neurologist or a pain specialist

Product Name: Dihydroergotamine nasal spray/inj, Trudhesa	
Diagnosis	Acute treatment of migraine
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has a diagnosis of headaches with or without aura</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The medication will be used for the acute treatment of migraine</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - One of the following:</p> <p><b>4.1</b> Patient has tried and failed or has intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan)</p> <p style="text-align: center;"><b>OR</b></p>	

**4.2** Patient has contraindication to all triptans

**AND**

**5** - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

**OR**

**6** - If the patient has more than four headaches days per month, **ONE** of the following:

**6.1** Patient is currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications

**OR**

**6.2** Patient is currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a contraindication or intolerance to these medications

**OR**

**6.3** Patient is currently being treated with a beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol) unless there is a contraindication or intolerance to these medications

**AND**

**7** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Dihydroergotamine nasal spray/inj, Trudhesa	
Diagnosis	Acute treatment of migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)

**AND**

2 - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

Product Name: Dihydroergotamine injection	
Diagnosis	Acute treatment of cluster headache episodes
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient has a diagnosis of cluster headache

**AND**

2 - Patient is 18 years of age or older

**AND**

3 - Patient has had a trial and failure, contraindication, or intolerance to sumatriptan injection

**AND**

**4** - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

**AND**

**5** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Dihydroergotamine injection

Diagnosis	Acute treatment of cluster headache episodes
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

**AND**

**2** - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

**2 . Revision History**

Date	Notes
1/20/2026	Updated GPIs. Added Zavzpret, Tosymra, Onzetra Xsail, Reyvow. Updated auth duration for triptans. Updated Ajovy age criteria. Updated Nurtec criteria for episodic migraine

Anti-Parkinson’s Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512217
<b>Guideline Name</b>	Anti-Parkinson’s Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name:Xadago	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Parkinson’s disease (PD)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is 5 years of age or older

**AND**

**3** - Documentation that patient will continue levodopa and/or other dopaminergic treatments

**AND**

**4** - Patient reports more than 1.5 hours per day “off” episodes (“off” episodes refer to “end-of-dose wearing off” and unpredictable “on/off” episodes)

**AND**

**5** - Patient will NOT concurrently be taking any of the following drugs: other MAO inhibitors (MAOIs) or other drugs that are potent inhibitors of MAOI (e.g., linezolid), opioid drugs (e.g., tramadol, meperidine, and related derivatives), SNRIs, tri- or tetra-cyclic or triazolopyridine antidepressants (TCAs), cyclobenzaprine, methylphenidate, amphetamine and their derivatives, St. John’s wort or dextromethorphan

**AND**

**6** - Patient does not have severe hepatic impairment (e.g., Child-Pugh C)

Product Name:Xadago	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response to Xadago therapy	

**AND**

**2** - Documentation that patient will continue levodopa and/or other dopaminergic treatments

Product Name: Duopa, Inbrija, brand Lodosyn, generic carbidopa tabs, Rytary, Crexont, Dhivy, Sinemet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - If the request is for a non-preferred medication, trial of ONE preferred agent</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Antibiotics



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-422556
<b>Guideline Name</b>	Antibiotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: cefixime, cefdinir, cefpodoxime	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Provider attestation that a third-generation cephalosporin is clinically indicated due to contraindications(s) to first-line therapy, treatment failure with first-line therapy, lack of alternative therapies, and/or proven resistance to other alternative treatment options</p> <p style="text-align: center;"><b>OR</b></p>	

**2** - Prescribed by an infectious disease specialist or by an emergency department provider

**OR**

**3** - If the request is for cefixime, medication is prescribed for gonococcal infection where ceftriaxone is unavailable

**OR**

**4** - A third-generation cephalosporin is being prescribed in the setting of severe penicillin allergy

**OR**

**5** - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Product Name: Brand Cipro, generic ciprofloxacin, levofloxacin, Baxdela, moxifloxacin, ofloxacin

Approval Length	30 Day(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Culture and sensitivity-proven susceptibilities and resistance to other agents suggest the requested drug is necessary

**OR**

**2** - Prescribed by an infectious disease specialist or by an emergency department provider

**OR**

**3** - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Product Name:Sivextro	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - ALL of the following:</p> <p><b>1.1</b> Diagnosis of Acute Bacterial Skin and Skin Structure Infection</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2</b> Infection is caused by methicillin-resistant Staphylococcus aureus (MRSA)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.3</b> ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patient had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns [e.g., trimethoprim/sulfamethoxazole (TMP/SMX), doxycycline, vancomycin, daptomycin, telavancin, clindamycin])</li> <li>• Patient started treatment with IV antibiotic(s) in the hospital and requires continued outpatient therapy</li> </ul>	

**OR**

**2** - Prescribed by an infectious disease specialist or by an emergency department provider

**OR**

**3** - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Product Name: Brand Zyvox, generic linezolid

Approval Length	30 Day(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - BOTH of the following:

**1.1** Diagnosis of vancomycin-resistant enterococcus (VRE) faecium infection or diagnosis of MRSA infection

**AND**

**1.2** ONE of the following:

- Patient had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns [e.g., TMP/SMX, doxycycline, vancomycin, tetracycline, clindamycin])
- Patient started treatment with IV antibiotic(s) in the hospital and requires continued outpatient therapy

**OR**

**2** - Prescribed by an infectious disease specialist or by an emergency department provider

**OR**

**3** - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

## **2 . Revision History**

Date	Notes
10/22/2025	New program

Anticonvulsants



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-492213
<b>Guideline Name</b>	Anticonvulsants
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name:Epidiolex	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of Lennox-Gastaut syndrome (LGS), Dravet Syndrome (DS) or Tuberous Sclerosis Complex (TSC)</p>	

**AND**

**2** - The patient is 1 year of age or older

**AND**

**3** - A recent serum transaminase (ALT and AST) and total bilirubin level has been obtained and is within normal limits

**AND**

**4** - The requested medication is prescribed by or in consultation with a neurologist

**AND**

**5** - The requested medication will be used as adjunctive therapy in recipients with uncontrolled seizure management (the patient has taken one or more antiepileptic drugs and has chart notes confirming persistent seizure events after titration of current anti-seizure regiment to highest tolerated doses)

**AND**

**6** - The total dose does NOT exceed one of the following:

- LGS/DS: 20 milligrams/kilogram/day (mg/kg/day) (10 mg/kg twice daily)
- TSC: 25 mg/kg/day (12.5 mg/kg twice daily)

Product Name: Epidiolex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of a positive clinical response to the requested medication

**AND**

2 - Serum transaminase (ALT and AST) and total bilirubin level has been re-checked per package insert

Product Name:Nayzilam	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of acute intermittent seizures

**AND**

2 - The patient is at least 12 years of age

**AND**

3 - The requested medication is prescribed by or in consultation with a neurologist

**AND**

4 - The dose must not exceed two sprays per seizure cluster, no more than one episode every three days and treat no more than five episodes per month

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name:Valtoco	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of epilepsy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient is at least 6 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The requested medication is prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - The requested medication is prescribed by or in consultation with a neurologist</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - The quantity requested does not exceed treatment for more than five episodes per month</p>	

Product Name:Fintepla	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of seizures associated with Dravet Syndrome

**AND**

2 - The patient is 2 years of age or older

**AND**

3 - The requested medication is prescribed by or in consultation with a neurologist

Product Name:Nayzilam, Valtoco, Fintepla	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of a positive clinical response to the requested medication</p>	

Product Name:Ztalmy	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is at least 2 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) confirmed with genetic testing

**AND**

**3** - The patient has tried and/or is concomitantly receiving at least 2 other anticonvulsant medications

**AND**

**4** - The requested medication is prescribed by or in consultation with a neurologist

**AND**

**5** - The daily dose does not exceed 1,800 milligrams

Product Name:Ztalmy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient continues to meet initial authorization criteria

**AND**

**2** - The prescriber attests to stabilization of disease or reduction in seizure frequency from baseline

**AND**

**3** - The patient has not experienced any treatment-restricting adverse effects (e.g., somnolence, pyrexia, suicidal thoughts, or behavior)

Product Name: Brand Aptiom, generic eslicarbazepine, Brand Banzel, generic rufinamide, Briviact (IV included), Brand Carbatrol, Brand Tegretol, Brand Tegretol XR, generic carbamazepine, generic carbamazepine ER, Brand Celontin, generic methsuximide, Brand Depakote, generic divalproex, Brand Depakote ER, generic divalproex ER, Diacomit, Brand Eprontia, Brand Topamax, generic topiramate, Brand Trokendi, generic topiramate ER, Spritam, Levetiracetam, Brand Keppra, generic levetiracetam, Brand Lamictal, Subvenite, generic lamotrigine, Brand Lamictal ODT, generic lamotrigine ODT, Brand Lamictal XR, generic lamotrigine ER, Brand Zarontin, generic ethosuximide, Brand Felbatol, generic felbamate, Brand Fycompa, generic perampanel, generic tiagabine, Brand Trileptal, generic oxcarbazepine, Brand Oxtellar XR, generic oxcarbazepine ER, Brand Sabril, Brand Vigadrone, generic vigabatrin, generic valproic acid, Brand Vimpat, generic lacosamide, Xcopri, Brand Zonegran, generic zonisamide, Brand Mysoline, generic primidone, generic phenobarbital, Brand Onfi, generic clobazam, Sympazan, Brand Klonopin, generic clonazepam, generic clonazepam ODT, generic clorazepate, Brand Valium, generic diazepam, Brand Cerebyx, generic fosphenytoin, Brand Dilantin, generic phenytoin, Phenytek, , generic phenytoin ER

Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - If the patient is less than 18 years of age, one of the following:

**1.1** The requested medication is being used for the treatment of a seizure disorder

**OR**

**1.2** The prescribing provider has a specialty in neurology or pediatric neurology

**OR**

**1.3** If the requested medication is being used for a behavioral health indication, one of the following:

**1.3.1** Patient has been discharged from an institutional facility within the past 6 months\* (please document name of discharge institution and date of discharge)

**OR**

**1.3.2** Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

**1.3.3** All of the following:

**1.3.3.1** The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

**1.3.3.2** The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**1.3.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**1.3.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**1.3.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**1.3.3.4** If the patient is less than 6 years of age, the requested medication is being utilized

for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Brand Lyrica IR, generic pregabalin IR, Brand Neurontin, generic gabapentin (generic Neurontin)

Approval Length	*Approval length if used for a behavioral health condition and patient has been discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - If the patient is less than 18 years of age, one of the following:

**1.1** The requested medication is being used for a non-behavioral health indication

**OR**

**1.2** The requested medication is being used for a behavioral health indication and patient meets one of the following:

**1.2.1** Patient has been discharged from an institutional facility within the past 6 months\* (please document name of discharge institution and date of discharge)

**OR**

**1.2.2** Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

**1.2.3** All of the following:

**1.2.3.1** The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

**1.2.3.2** The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**1.2.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**1.2.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**1.2.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**1.2.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Antidepressants



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512219
<b>Guideline Name</b>	Antidepressants
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name: Brand Wellbutrin SR/XL, generic bupropion IR/SR/ER/XL, Forfivo XL, Bupropion XL, Aplenzin, Auvelity, Desvenlafaxine ER, Brand Pristiq, generic desvenlafaxine ER, Brand Effexor XR, generic venlafaxine IR/ER, Venlafaxine besylate ER, Fetzima, Brand Remeron, generic mirtazapine, generic trazodone, Trintellix, Brand Viibryd, generic vilazodone, Zurzuvae, Brand Celexa, generic citalopram, Citalopram, generic fluvoxamine, generic fluvoxamine ER, Brand Lexapro, generic escitalopram, Brand Paxil, generic paroxetine, Brand Paxil CR, generic paroxetine ER, Brand Prozac, generic fluoxetine, Brand Zoloft, generic sertraline	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - If the patient is less than 18 years of age, one of the following:

**1.1** Patient has been discharged from an institutional facility within the past 6 months\* (please document name of discharge institution and date of discharge)

**OR**

**1.2** Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

**1.3** All of the following:

**1.3.1** The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

**1.3.2** The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**1.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**1.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**1.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**1.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:generic duloxetine	
Approval Length	*Approval length if used for a behavioral health condition and patient has been discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - If the patient is less than 18 years of age, one of the following:</p> <p><b>1.1</b> The requested medication is being used for a non-behavioral health indication</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> The requested medication is being used for a behavioral health indication and patient meets one of the following:</p> <p><b>1.2.1</b> Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)</p> <p style="text-align: center;"><b>OR</b></p>	

**1.2.2** Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

**1.2.3** All of the following:

**1.2.3.1** The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

**1.2.3.2** The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**1.2.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**1.2.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**1.2.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**1.2.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Antiemetics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-404253
<b>Guideline Name</b>	Antiemetics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:generic granisetron, generic ondansetron, Anzemet	
Approval Length	6 month(s)*
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 The patient has failed on chemotherapy-related antiemetic therapy at lower doses</p> <p style="text-align: center;"><b>OR</b></p>	

**1.2** The patient is receiving chemotherapy treatments more often than once a week

**OR**

**1.3** The patient has a diagnosis of Acquired Immune Deficiency Syndrome (AIDS), associated nausea and vomiting

**OR**

**1.4** Both of the following:

- The patient has a diagnosis of hyperemesis gravidarum
- The patient has failed at least one other antiemetic therapy or all other available therapies are medically contraindicated

Notes

\*Allow for a 30-day fill

Product Name:generic granisetron, generic ondansetron, Anzemet

Approval Length | 12 month(s)

Guideline Type | Prior Authorization

**Approval Criteria**

1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Brand Marinol, generic dronabinol, Syndros

Approval Length | 12 month(s)

Guideline Type | Prior Authorization

**Approval Criteria**

1 - One of the following:

**1.1** The patient has a diagnosis of chemotherapy-induced nausea and/or vomiting and all of the following:

**1.1.1** The patient has experienced an inadequate response, adverse event or has a contraindication to at least one serotonin receptor antagonist

**AND**

**1.1.2** The patient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent

**AND**

**1.1.3** The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the patient

**OR**

**1.2** The patient has been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) and has anorexia associated with weight loss and meets both of the following:

**1.2.1** The patient has experienced an inadequate response, adverse event or has a contraindication to megestrol (Megace)

**AND**

**1.2.2** The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the patient

## 2 . Revision History

Date	Notes
10/2/2025	Added NP check for generic granisetron, generic ondansetron, Anzemet

Antihemophilic Agents



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-423187
<b>Guideline Name</b>	Antihemophilic Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Hemofil M, Koate, Koate-DVI, Recombinate, Kogenate FS, Nuwiq, Advate, Kovaltry, Xyntha, Xyntha Solofuse, Eloctate, Altuviiiio, Novoeight, Esperoct, Adynovate, Jivi, Obizur, Afstylya, Humate-P, Alphanate, Wilate, Feiba, Novoseven RT, Sevenfact, Alphanine SD, Rixubis, Ixinity, Benefix, Idelvion, Alprolix, Rebinyn, Profilnine, Coagadex, Tretten, Corifact, Kcentra, Vonvendi, Qfitlia, Alhemo, Hemlibra, Hympavzi, Ryplazim	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p>	

**1.1** The requested medication is being prescribed for an FDA (Food and Drug Administration) approved indication

**OR**

**1.2** The patient's diagnosis is supported as a use of American Hospital Formulary Service Drug Information (AHFS DI)

**OR**

**1.3** One of the following:

**1.3.1** The patient's diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table)

**OR**

**1.3.2** Both of the following:

- The patient's diagnosis is listed in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of III or Class Indeterminant (see DRUGDEX Strength of Recommendation table)
- Efficacy is rated as “effective” or “evidence favors efficacy” (see DRUGDEX Efficacy Rating and PA Approval Status table)

**OR**

**1.3.3** The patient's diagnosis is supported in any other section of DRUGDEX

**OR**

**1.4** The use is supported by clinical research in two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal and one of the following:

**1.4.1** The dosage quantity/duration of the medication is reasonably safe and effective based

on information contained in the FDA approved labeling, peer-reviewed medical literature, or accepted standards of medical practice

**OR**

**1.4.2** The dosage/quantity/duration of the medication is reasonably safe and effective based on one of the following compendia:

- AHFS Compendium
- Thomson Reuters (Healthcare) Micromedex/ DRUGDEX (not Drug Points) Compendium
- Elsevier Gold Standard's Clinical Pharmacology Compendium
- National Comprehensive Cancer Network Drugs and Biologics Compendium

**AND**

**2** - The dispensing provider will monitor the amount of product the patient has left to avoid over-stock

**AND**

**3** - The prescriber is a specialist in treating hemophilia

## 2 . Revision History

Date	Notes
10/16/2025	New guideline

Antipsychotics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512220
<b>Guideline Name</b>	Antipsychotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name:Nuplazid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has Parkinson's related psychosis</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 18 years of age or older</p>	

Product Name: Brand Abilify, generic aripiprazole, Abilify Mycite, Brand Clozaril, generic clozapine, Fanapt, Brand Latuda, generic lurasidone, Secuado, Brand Saphris, generic asenapine, Caplyta, Brand Geodon, generic ziprasidone, Brand Invega tablets, generic paliperidone ER tablets, Lybalvi, Brand Risperdal, generic risperidone, Brand Seroquel, generic quetiapine, Brand Seroquel XR, generic quetiapine ER, Brand Zyprexa, generic olanzapine, Rexulti, Vraylar, lithium, Brand Lithobid, generic lithium ER

Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - If the patient is less than 18 years of age, one of the following:

1.1 Patient has been discharged from an institutional facility within the past 6 months\* (please document name of discharge institution and date of discharge)

**OR**

1.2 Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

1.3 All of the following:

1.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

1.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**1.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**1.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**1.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**1.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Anxiolytics, Sedatives and Hypnotics



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-512221
<b>Guideline Name</b>	Anxiolytics, Sedatives and Hypnotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name: Brand Ambien, generic zolpidem, Zolpidem, Brand Ambien CR, generic zolpidem ER, generic zolpidem SL, Edluar, Belsomra, generic estazolam, generic quazepam, generic flurazepam, Brand Lunesta, generic eszopiclone, Brand Rozerem, generic ramelteon, Brand Restoril, generic temazepam, Brand Silenor, generic doxepin tabs, Brand Halcion, generic triazolam, generic zaleplon	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of insomnia</p>	

**AND**

**2** - If the patient is less than 18 years of age, one of the following:

**2.1** Patient has been discharged from an institutional facility within the past 6 months\* (please document name of discharge institution and date of discharge)

**OR**

**2.2** Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

**2.3** All of the following:

**2.3.1** The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

**2.3.2** The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**2.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**2.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**2.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**2.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Arikayce



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-434341
<b>Guideline Name</b>	Arikayce
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of refractory Mycobacterium avium complex (MAC) lung disease

**AND**

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting respiratory cultures positive for MAC within the previous 6 months

**AND**

3 - Submission of medical records (e.g., chart notes, laboratory values) or prescription claims history documenting the patient has been receiving a multidrug background regimen containing at least TWO of the following agents for a minimum of 6 consecutive months within the past 12 months:

- Macrolide antibiotic (e.g., azithromycin, clarithromycin)
- Ethambutol
- Rifamycin antibiotic (e.g., rifampin, rifabutin)

**AND**

4 - Patient will continue to receive a multidrug background regimen

**AND**

5 - Documentation that the patient has NOT achieved negative sputum cultures after receipt of a multidrug background regimen for a minimum of 6 consecutive months

**AND**

6 - In vitro susceptibility testing of recent (within 6 months) positive culture documents that the MAC isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than or equal to 64 micrograms per milliliter (mcg/mL)

**AND**

**7** - Prescribed by or in consultation with **ONE** of the following:

- Infectious disease specialist
- Pulmonologist

Product Name:Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - <b>ONE</b> of the following:</p> <p><b>1.1</b> Documentation that the patient has achieved negative respiratory cultures</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> <b>ALL</b> of the following:</p> <p><b>1.2.1</b> Patient has <b>NOT</b> achieved negative respiratory cultures while on Arikayce</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2.2</b> Physician attestation that patient has demonstrated clinical benefit while on Arikayce</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2.3</b> In vitro susceptibility testing of most recent (within 6 months) positive culture with</p>	

available susceptibility testing documents that the Mycobacterium avium complex (MAC) isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than 64 micrograms per milliliter (mcg/mL)

**AND**

**1.2.4** Patient has NOT received greater than 12 months of Arikayce therapy with continued positive respiratory cultures

**AND**

**2** - Submission of medical records (e.g., chart notes, laboratory values) or prescription claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents:

- Macrolide antibiotic (e.g., azithromycin, clarithromycin)
- Ethambutol
- Rifamycin antibiotic (e.g., rifampin, rifabutin)

**AND**

**3** - Prescribed by or in consultation with ONE of the following:

- Infectious disease specialist
- Pulmonologist

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary. LKC

Attruby



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434340
<b>Guideline Name</b>	Attruby
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Attruby	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - One of the following:</b></p> <p><b>2.1 Documentation that the patient has a pathogenic TTR mutation (e.g., V30M)</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.3 All of the following:</b></p> <ul style="list-style-type: none"> <li>• Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis</li> <li>• Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*</li> <li>• Absence of light chain amyloidosis</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Physician attests that the patient has an N-terminal pro-B-type natriuretic peptide (NT-proBNP) level that, when combined with signs and symptoms, is considered definitive for a diagnosis of ATTR-CM</b></p>	

**AND**

**5** - One of the following:

- History of heart failure, with at least one prior hospitalization for heart failure
- Presence of signs and symptoms of heart failure (e.g., dyspnea, edema)

**AND**

**6** - Prescribed by or in consultation with a cardiologist

**AND**

**7** - Patient is not receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

Notes	*May require prior authorization and notification
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Product Name:Attruby	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation that the patient has experienced a positive clinical response to Attruby (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure</p>	

**AND**

**3** - Prescribed by or in consultation with a cardiologist

**AND**

**4** - Patient is not receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary - LKC

Auvi-Q (epinephrine injection device)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-421298
<b>Guideline Name</b>	Auvi-Q (epinephrine injection device)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Auvi-Q	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient or caregiver is unable to read or comprehend written directions</p>	

### 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/15/2025	New program

Azole Antifungals



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-434342
<b>Guideline Name</b>	Azole Antifungals
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of ONE of the following:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

**OR**

2 - BOTH of the following:

2.1 Diagnosis of coccidioidomycosis

**AND**

2.2 ONE of the following:

2.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

**OR**

2.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - Diagnosis of fingernail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of toenail onychomycosis confirmed by ONE of the following:</p> <ul style="list-style-type: none"> <li>• KOH (potassium hydroxide) test</li> <li>• Fungal culture</li> <li>• Nail biopsy</li> </ul>	

Product Name:Brand Sporanox capsules, generic itraconazole capsules
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

Product Name: Brand Sporanox oral solution, generic itraconazole oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Oropharyngeal candidiasis</li> <li>• Esophageal candidiasis</li> </ul>	

Product Name: Brand Vfend tablets, generic voriconazole tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of invasive aspergillosis</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - ALL of the following:</p>	

**2.1** Diagnosis of candidemia

**AND**

**2.2** Patient is non-neutropenic

**AND**

**2.3** ONE of the following:

**2.3.1** Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

**OR**

**2.3.2** History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

**OR**

**3** - BOTH of the following:

**3.1** ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

**AND**

**3.2** ONE of the following:

**3.2.1** Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

**OR**

**3.2.2** History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

**OR**

**4** - Diagnosis of *Scedosporium apiospermum* infection (asexual form of *Pseudallescheria boydii*)

**OR**

**5** - Diagnosis of *Fusarium* spp. infection including *Fusarium solani*

**OR**

**6** - Diagnosis of *Exserohilum* species infection

Product Name: Brand Vfend susp, generic voriconazole susp	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - ONE of the following:</p> <p><b>1.1</b> Diagnosis of invasive aspergillosis including <i>Aspergillus fumigatus</i></p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> ALL of the following:</p> <p><b>1.2.1</b> Diagnosis of Candidemia</p>	

**AND**

**1.2.2** Patient is non-neutropenic

**AND**

**1.2.3** ONE of the following:

**1.2.3.1** Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

**OR**

**1.2.3.2** History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

**OR**

**1.3** BOTH of the following:

**1.3.1** ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

**AND**

**1.3.2** ONE of the following:

**1.3.2.1** Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

**OR**

**1.3.2.2** History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

**OR**

**1.4** Diagnosis of *Scedosporium apiospermum* infection (asexual form of *Pseudallescheria boydii*)

**OR**

**1.5** Diagnosis of *Fusarium* spp. infection including *Fusarium solani*

**OR**

**1.6** Diagnosis of *Exserohilum* species infection

**AND**

**2** - Physician has provided rationale for the patient needing to use voriconazole oral suspension instead of voriconazole tablets

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Used as prophylaxis of invasive fungal infections caused by ONE of the following:</p>	

- Aspergillus
- Candida

**AND**

**2** - ONE of the following conditions:

**2.1** Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

**2.1.1** Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

**OR**

**2.1.2** Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

**OR**

**2.2** Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Treatment of Invasive Aspergillosis
Approval Length	84 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of invasive aspergillosis</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - ONE of the following:</p>	

**2.1** Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

Product Name: Brand Noxafil suspension, generic posaconazole suspension, Noxafil delayed release suspension packets

Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

**AND**

**2** - ONE of the following conditions:

**2.1** Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

**2.1.1** Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

**OR**

**2.1.2** Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

**OR**

**2.2** Patient has a prior fungal infection requiring secondary prophylaxis

Product Name: Brand Noxafil suspension, generic posaconazole suspension	
Diagnosis	Oropharyngeal Candidiasis (OPC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of oropharyngeal candidiasis (OPC)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p><b>2.1</b> Failure to ONE of the following as confirmed by claims history or submission of medical records:</p> <ul style="list-style-type: none"> <li>• Fluconazole (generic Diflucan)</li> <li>• Itraconazole (generic Sporanox)</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> History of contraindication, intolerance, or resistance to BOTH of the following (please specify intolerance, contraindication, or resistance):</p> <ul style="list-style-type: none"> <li>• Fluconazole (generic Diflucan)</li> <li>• Itraconazole (generic Sporanox)</li> </ul>	

Product Name: Cresemba	
Approval Length	3 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - BOTH of the following:</p> <p>1.1 Diagnosis of invasive aspergillosis</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 ONE of the following:</p> <p>1.2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Diagnosis of invasive mucormycosis</p>	

Product Name: Tolsura	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following fungal infections:</p> <ul style="list-style-type: none"> <li>• Blastomycosis</li> <li>• Histoplasmosis</li> </ul>	

<ul style="list-style-type: none"> <li>Aspergillosis</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <p><b>2.1</b> Failure to itraconazole capsules (generic Sporanox) as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> History of contraindication or intolerance to itraconazole capsules (generic Sporanox) (please specify intolerance or contraindication)</p>
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Product Name: Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, generic voriconazole tablets, Brand Vfend suspension, generic voriconazole suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil delayed release suspension packets, Cresamba, Tolsura	
Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Approval Length	Based on provider and IDSA recommended treatment durations, up to 12 months
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Use is recognized for treatment of the diagnosis by the Infectious Diseases Society of America (IDSA)</p>	

**2 . Revision History**

Date	Notes
11/4/2025	Added Nevada Formulary

Benefit Determination Mifeprex



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434343
<b>Guideline Name</b>	Benefit Determination Mifeprex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Florida MMA (CSFL, CSFLD)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Kansas (ACUKS, ACUKSC, ACUKSEC)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Texas (ACUTX, ACUTXC, ACUTXEC, ACUTXSK)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Mifeprex, generic mifepristone	
Approval Length	1 month(s)
Guideline Type	Benefit Determination

**Approval Criteria**

1 - Provider attests patient requires treatment for purposes identified in the Hyde amendment and any applicable state laws and regulations

**AND**

2 - Submission of all necessary state form(s) and/or certification document(s)

**2 . Revision History**

Date	Notes
11/4/2025	Added Nevada Formulary

Benlysta



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-380424
<b>Guideline Name</b>	Benlysta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Benlysta	
Diagnosis	Systemic Lupus Erythematosus (SLE)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of active Systemic Lupus Erythematosus (SLE)</p>	

**AND**

**2** - Patient meets the age requirement for the requested formulation:

- Benlysta IV & autoinjector: 5 years of age or older
- Benlysta prefilled syringe: 18 years of age or older

**AND**

**3** - Documentation confirms that the patient is autoantibody positive (i.e., anti-nuclear antibody [ANA] and/or anti-double-stranded deoxyribonucleic acid [anti-dsDNA])

**AND**

**4** - The patient is currently receiving at least one standard of care treatment for active SLE that includes one or more of the following agents (unless all agents are contraindicated):

- Antimalarials (e.g., Plaquenil (hydroxychloroquine))
- Corticosteroids (e.g., prednisone)
- Glucocorticoids
- Immunosuppressants (e.g., methotrexate, Imuran (azathioprine), mycophenolate)

**AND**

**5** - Medication is prescribed by or in consultation with a rheumatologist

**AND**

**6** - Patient does NOT have active central nervous system (CNS) lupus

**AND**

**7** - Patient is currently NOT receiving treatment for a chronic infection

**AND**

**8** - Patient does NOT have evidence of severe renal disease

Product Name: Benlysta	
Diagnosis	Lupus Nephritis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of active lupus nephritis</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient meets the age requirement for the requested formulation:</p> <ul style="list-style-type: none"> <li>• Benlysta IV: 5 years of age or older</li> <li>• Benlysta prefilled syringe &amp; autoinjector: 18 years of age or older</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient is currently receiving at least one standard of care treatment that includes one or more of the following agents (unless all agents are contraindicated):</p> <ul style="list-style-type: none"> <li>• Antimalarials (e.g., Plaquenil (hydroxychloroquine))</li> <li>• Corticosteroids (e.g., prednisone)</li> <li>• Glucocorticoids</li> <li>• Immunosuppressants (e.g., methotrexate, Imuran (azathioprine), mycophenolate)</li> </ul> <p style="text-align: center;"><b>AND</b></p>	

**4** - Medication is prescribed by or in consultation with a rheumatologist or nephrologist

**AND**

**5** - Patient does NOT have active central nervous system (CNS) lupus

**AND**

**6** - Patient is currently NOT receiving treatment for a chronic infection

<b>Product Name: Benlysta</b>	
Diagnosis	Systemic Lupus Erythematosus (SLE), Lupus Nephritis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response to Benlysta therapy	

## 2 . Revision History

Date	Notes
9/4/2025	New

Besremi



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-435256
<b>Guideline Name</b>	Besremi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Besremi
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Diagnosis	Polycythemia Vera
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of polycythemia vera</p>	

Product Name:Besremi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p>	

Product Name:Besremi	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Besremi therapy</p>	

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/4/2025	Combined formularies - added AZ, NV, VA, WA, IN, NM. No clinical changes.

Bile Acid Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-458420
<b>Guideline Name</b>	Bile Acid Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Ctexli	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of cerebrotendinous xanthomatosis (CTX) genetically confirmed by a mutation in the CYP27A1 gene</p>	

<b>AND</b>
<b>2</b> - Patient is at least 18 years of age
<b>AND</b>
<b>3</b> - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, endocrinologist, or other specialist with advanced knowledge in treating CTX

Product Name:Ctexli	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, endocrinologist, or other specialist with advanced knowledge in treating CTX</p>	

Product Name:Cholbam	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p>	

**1** - The requested medication is being prescribed for one of the following:

**1.1** Treatment of Bile Acid Synthesis Disorder due to Single Enzyme Defects (SEDs)

**OR**

**1.2** Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption

**AND**

**2** - Diagnosis confirmed by one of the following:

- Abnormal urinary bile acid by Fast Atom Bombardment ionization-Mass Spectrometry (FAB-MS) analysis
- Genetic testing consistent with diagnosis

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a gastroenterologist or hepatologist

Product Name: Cholbam	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is without any treatment-restricting adverse events (including complete biliary obstruction)

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a gastroenterologist or hepatologist

## **2 . Revision History**

Date	Notes
12/8/2025	New guideline

Biltricide



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434344
<b>Guideline Name</b>	Biltricide
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Biltricide, generic praziquantel
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Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 Infections due to schistosoma</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2 Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis viverrini (i.e., clonorchiasis or opisthorchiasis)</p>	

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Botulinum Toxin



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422549
<b>Guideline Name</b>	Botulinum Toxin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Dysport, Botox, Myobloc, Xeomin	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The provider attests they are familiar with and experienced in the use of botulinum toxin products and utilize FDA-approved product labeling, compendia, and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each patient condition</p>	

**AND**

**2** - The provider attests the requested medication is being used for a covered condition found within the “Provider Type 20, 24, and 77 Billing Guide” applicable to botulinum toxins

**AND**

**3** - Submission of medical records documenting patient has been unresponsive to conventional methods of treatment (e.g., medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions)

**AND**

**4** - Provider attests that if maximum dose is reached and positive clinical response is not established, treatment will be discontinued

**AND**

**5** - ONE of the following:

- Treatment is NOT more frequent than every 90 days
- Documentation of medical necessity is required for treatment more frequent than every 90 days (document rationale)

**AND**

**6** - Request is for treatment of one injection per site (a site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, or neck)

**AND**

**7** - Requested medication is NOT being used for cosmetic or investigational purposes

Product Name: Dysport, Botox, Myobloc, Xeomin

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b> 1 - Documentation of a positive clinical response to therapy	

## 2 . Revision History

Date	Notes
10/22/2025	New program

Brineura (cerliponase alfa)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-390193
<b>Guideline Name</b>	Brineura (cerliponase alfa)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Brineura	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis Type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency</p>	

**AND**

**2** - Diagnosis confirmed by TPP1 enzyme detected by a dried blood spot test and CLN2 genotype analysis

**AND**

**3** - Patient is 3 years of age or older

**AND**

**4** - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of CLN2

**AND**

**5** - Administered by, or under the direction of, a physician knowledgeable in intraventricular administration

**AND**

**6** - Patient does NOT have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections)

**AND**

**7** - Patient does NOT have a ventriculoperitoneal shunt

Product Name: Brineura	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient does NOT have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections)

**AND**

2 - Patient does NOT have a ventriculoperitoneal shunt

**AND**

3 - Documentation of positive clinical response to Brineura (e.g., improvement in walking or crawling, or no evidence of disease progression)

**2 . Revision History**

Date	Notes
9/8/2025	New program.

Brinsupri



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-501247
<b>Guideline Name</b>	Brinsupri
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>•</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Brinsupri
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a diagnosis of non-cystic fibrosis bronchiectasis</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has ALL of the following signs and symptoms associated with bronchiectasis:</p> <ul style="list-style-type: none"> <li>• Cough most days of the week lasting greater than 3 months</li> <li>• Production of mucopurulent sputum most days of the week lasting greater than 3 months</li> <li>• Recurrent respiratory tract infections</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Chest computed tomography (CT) is positive for bronchiectasis</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Cystic fibrosis has been ruled out by one of the following:</p> <ul style="list-style-type: none"> <li>• Sweat chloride test is negative</li> <li>• Mutation analysis of the cystic fibrosis transmembrane conductance regulator (CFTR) gene is negative for cystic fibrosis</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - ONE of the following:</p> <p><b>5.1</b> If the patient is 12 to 17 years of age, patient has experienced one or more pulmonary exacerbation(s) requiring systemic antimicrobial therapy in the previous 12 months</p>	

**OR**

**5.2** If the patient is 18 years of age or older, patient has experienced two or more pulmonary exacerbations requiring systemic antimicrobial therapy in the previous 12 months

**AND**

**6** - ONE of the following:

**6.1** Patient does not have co-existing COPD or asthma

**OR**

**6.2** Patient has co-existing COPD, AND patient is currently being treated with one of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., tiotropium, umeclidinium) AND a long-acting beta agonist (LABA) (e.g., salmeterol, arformoterol, formoterol)
- Triple therapy [LAMA plus LABA combined with an inhaled corticosteroid (ICS) (e.g., budesonide, fluticasone propionate)]

**OR**

**6.3** Patient has co-existing asthma, AND the patient is currently being treated with one of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Dual therapy with a LABA (e.g., salmeterol, arformoterol, formoterol) AND ICS (e.g., budesonide, fluticasone propionate)
- Triple therapy with a LAMA (e.g., tiotropium, umeclidinium) plus LABA (e.g., salmeterol, arformoterol, formoterol) combined with an ICS (e.g., budesonide, fluticasone propionate)]

**AND**

7 - Prescribed by or in consultation with a pulmonologist

Product Name: Brinsupri

Approval Length | 12 month(s)

Therapy Stage | Reauthorization

Guideline Type | Prior Authorization

**Approval Criteria**

1 - Documentation of a positive clinical response (e.g, the patient has not had an increase in the number of annual pulmonary exacerbations requiring treatment with systemic antibiotics, patient has not initiated therapy with long-term maintenance systemic or inhaled antibiotics since starting Brinsupri)

**AND**

2 - ONE of the following:

2.1 Patient does not have co-existing COPD or asthma

**OR**

2.2 Patient has co-existing COPD, AND continues to be treated with one of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., tiotropium, umeclidinium) AND a long-acting beta agonist (LABA) (e.g., salmeterol, arformoterol, formoterol)
- Triple therapy [LAMA plus LABA combined with an inhaled corticosteroid (ICS) (e.g., budesonide, fluticasone propionate)]

**OR**

2.3 Patient has co-existing asthma, AND continues to be treated with one of the following

therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Dual therapy with a LABA (e.g., salmeterol, arformoterol, formoterol) AND ICS (e.g., budesonide, fluticasone propionate)
- Triple therapy with a LAMA (e.g., tiotropium, umeclidinium) plus LABA (e.g., salmeterol, arformoterol, formoterol) combined with an ICS (e.g., budesonide, fluticasone propionate)]

**AND**

**3** - Prescribed by or in consultation with a pulmonologist

## 2 . Revision History

Date	Notes
1/16/2026	New

Bronchitol



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434346
<b>Guideline Name</b>	Bronchitol
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Bronchitol	
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of cystic fibrosis (CF)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Used in conjunction with standard CF therapies [e.g., chest physiotherapy, bronchodilators, antibiotics, anti-inflammatory therapy (e.g., ibuprofen, oral/inhaled corticosteroids)]</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient has passed the Bronchitol Tolerance Test</p>	

Product Name:Bronchitol	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Bronchitol therapy</p>	

**2 . Revision History**

Date	Notes
11/4/2025	Added Nevada Formulary, - LKC

Buphenyl



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434347
<b>Guideline Name</b>	Buphenyl
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

#### Guideline Note:

Effective Date:	1/1/2026
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#### 1 . Criteria

Product Name: Brand Buphenyl oral powder, generic sodium phenylbutyrate oral powder	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of urea cycle disorders (UCDs)</p>	

Product Name:Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of urea cycle disorders (UCDs)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescriber provides a reason or special circumstance the patient cannot use sodium phenylbutyrate (generic Buphenyl) powder for oral solution</p>	

Product Name:Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Buphenyl (sodium phenylbutyrate) tablets</p>	

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-511290
<b>Guideline Name</b>	C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Florida MMA (CSFL, CSFLD)</li> <li>• Medicaid - Community &amp; State Louisiana (ACULA, ACULAC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**Note:**

EPSDT does not apply to drugs listed in Table 1.

**1 . Criteria**

Diagnosis	Exception to Policy Limitations for Medicaid Patients Less Than 21 Years of Age^
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 The use of the requested medication is for an indicated diagnosis that is supported by the Food and Drug Administration (FDA)</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2 The use of the requested medication is supported by information from ONE of the following appropriate compendia of current literature:</p> <ul style="list-style-type: none"> <li>• American Hospital Formulary Service Drug Information</li> <li>• National Comprehensive Cancer Network Drugs and Biologics Compendium</li> <li>• Thomson Micromedex DrugDex</li> <li>• Clinical pharmacology</li> <li>• United States Pharmacopoeia-National Formulary</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - The use of the requested medication is NOT for experimental or investigational purposes</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescriber attests that the requested medication is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition (health problem)</p> <p style="text-align: center;"><b>AND</b></p>	

**4** - Prescriber attests the requested medication is an accepted method for treatment (medical practice)

**AND**

**5** - Prescriber attests the requested medication is the least costly treatment of equally effective choices

**AND**

**6** - Prescriber attests the requested medication is safe and effective

**AND**

**7** - Submission of medical records (e.g. chart notes, assessments, treatment plans, monitoring plans, etc.) confirming previous and current treatments used to treat diagnosis (Must include regimen, duration, treatment goals, and response to treatment)

**AND**

**8** - The requested medication is prescribed within the dosing guidelines from ONE of the following:

**8.1** The manufacturer's published dosing guidelines

**OR**

**8.2** ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary

Notes	^ This criteria does not apply to CSFLD and ACUFLEC. Note: ACUFL EC does not have Rx benefits. ^ This criteria does NOT apply to ACUNE/ ACUNEEL1
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## 2 . Background

Benefit/Coverage/Program Information
<p><b>Table 1: EPSDT does not apply to the following drugs</b></p>
Abecma
Acthar
Acthar gel
Agamree
Beqvez
Casgevy
Cortrophin
Crenessity
Egrifta SV
Egrifta WR
Elevidys
Encelto
Epclusa
Evrysdi
Genotropin
Genotropin Miniquick
Hemgenix
Humatrope

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Humira
Increlex
Kebilidi
Ledipasvir/sofosbuvir
Lenmeldy
Leqembi
Luxturna
Lyfgenia
Mavyret
Ngenla
Norditropin Flexpro
Nutropin AQ Nuspin 10
Nutropin AQ Nuspin 20
Nutropin AQ Nuspin 5
Omnitrope
Onpattro
Papzimeos
Ribavirin
Roctavian
Saizen
Serostim
Skysona
Skytrofa
Sofosbuvir/velpatasvir
Sogroya

Solvadi
Spinraza
Stelara
Strensiq
Synagis
Tabloid
Tecelra
Vosevi
Voxzogo
Vyjuvek
Yescarta
Zepatier
Zolgensma
Zomacton
Zorbtive
Zynteglo

### 3 . Revision History

Date	Notes
2/3/2026	Corrected the go-live date to 2/3/26

Cabenuva and Vocabria



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-422494
<b>Guideline Name</b>	Cabenuva and Vocabria
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Cabenuva, Vocabria	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 The requested medication is being used for continuation of prior therapy</p> <p style="text-align: center;"><b>OR</b></p>	

**1.2** All of the following:

**1.2.1** Patient has a diagnosis of HIV (Human immunodeficiency virus)-1 infection

**AND**

**1.2.2** Patient is currently virologically suppressed [HIV-1 RNA (Ribonucleic Acid) less than 50 copies/mL (milliliter)] on a stable, uninterrupted antiretroviral regimen for at least six months

**AND**

**1.2.3** Patient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine

**AND**

**1.2.4** Prescribed by, or in consultation with, a clinician with HIV expertise

**AND**

**1.2.5** Will not be used concurrently with other ART (Antiretroviral therapy) medications

## 2 . Revision History

Date	Notes
10/20/2025	New guideline

Cablivi



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434348
<b>Guideline Name</b>	Cablivi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)

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Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Cablivi was initiated as a bolus intravenous injection administered by a healthcare provider in combination with plasma exchange therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange</p>	

Product Name: Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Request is for a new (different) episode requiring the re-initiation of plasma exchange for the treatment of acquired thrombotic thrombocytopenic purpura (aTTP) (Documentation of date of prior episode and documentation date of new episode required)</p>	

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Camzyos



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-434349
<b>Guideline Name</b>	Camzyos
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Camzyos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Heart failure is classified as ONE of the following:</p> <ul style="list-style-type: none"><li>• New York Heart Association (NYHA) class II heart failure</li><li>• NYHA class III heart failure</li></ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient has a left ventricular ejection fraction of greater than or equal to 55%</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Patient has a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - ONE of the following:</p> <p><b>5.1</b> Failure to ONE of the following as confirmed by claims history or submission of medical records:</p> <ul style="list-style-type: none"><li>• Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)</li><li>• Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)</li></ul> <p style="text-align: center;"><b>OR</b></p> <p><b>5.2</b> History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):</p>	

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

**AND**

**6** - Camzyos is prescribed by, or in consultation with, a cardiologist

Product Name: Camzyos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (e.g., reduction in NYHA class, no worsening in NYHA class)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has a left ventricular ejection fraction of greater than or equal to 50%</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Camzyos is prescribed by, or in consultation with, a cardiologist</p>	

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Carbaglu



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-434813
<b>Guideline Name</b>	Carbaglu
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of hyperammonemia due to ONE of the following:</p> <ul style="list-style-type: none"> <li>• N-acetylglutamate synthase (NAGS) deficiency</li> <li>• Propionic acidemia (PA)</li> <li>• Methylmalonic acidemia (MMA)</li> </ul>	

Product Name: Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to the requested therapy</p>	

## 2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Cayston (aztreonam)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-395197
<b>Guideline Name</b>	Cayston (aztreonam)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Cayston	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 7 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Submission of medical records, chart notes, labs, etc., documenting a diagnosis of Cystic Fibrosis (CF) with positive sputum culture confirming pseudomonas aeruginosa of the airway

**AND**

**3** - The patient has FEV1 between 25% and 75% predicted

**AND**

**4** - The prescriber attests that the patient is not colonized with Burkholderia cepacian

**AND**

**5** - One of the following:

- Trial and failure, contraindication, or intolerance to inhaled tobramycin
- Antibiotic susceptibility testing indicates aztreonam to be more effective than tobramycin

**AND**

**6** - Cayston will be dosed per FDA label (75 mg every eight hours administered with 28 days on/28 days off cycle) and the patient was counseled to use bronchodilator before taking a dose of Cayston)

Product Name: Cayston	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Positive response to therapy as demonstrated by improvement in CF respiratory symptoms	

**AND**

**2** - The patient has not experienced any treatment-restricting adverse effects (e.g., bronchospasms, allergic reactions)

## **2 . Revision History**

Date	Notes
9/10/2025	1/1/2026 Implementation

Cerdelga and Zavesca



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-435249
<b>Guideline Name</b>	Cerdelga and Zavesca
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Cerdelga	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Gaucher disease type 1</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is ONE of the following as detected by an FDA-cleared test:</p> <ul style="list-style-type: none"> <li>• CYP2D6 extensive metabolizer</li> <li>• CYP2D6 intermediate metabolizer</li> <li>• CYP2D6 poor metabolizer</li> </ul>	

Product Name: Brand Zavesca, generic miglustat, Yargesa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ALL of the following:</p> <p>1.1 Diagnosis of mild to moderate type 1 Gaucher disease</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 Patient is unable to receive enzyme replacement therapy due to ONE of the following conditions:</p> <ul style="list-style-type: none"> <li>• Allergy or hypersensitivity to enzyme replacement therapy</li> <li>• Poor venous access</li> <li>• Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)</li> </ul>	

**OR**

**2** - ALL of the following:

- Diagnosis of Niemann-Pick disease type C (NPC)
- Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes
- Provider attests patient presents with neurological manifestations of NPC

Product Name: Cerdelga, Brand Zavesca, generic miglustat, Yargesa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy</p>	

**2 . Revision History**

Date	Notes
11/4/2025	Added NV formulary. No clinical updates.

Chantix



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439188
<b>Guideline Name</b>	Chantix
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Chantix, varenicline, apo-varenicline	
Approval Length	6 Month(s)*
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has not exceeded 180 days of therapy in the last 12 months</p>	

**AND**

**2** - Treatment is being requested for tobacco cessation

**AND**

**3** - ONE of the following:

**3.1** Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Nicotine replacement patches OTC (over the counter) (e.g., Nicoderm CQ-OTC)
- Nicotine gum OTC (e.g., Nicorette gum-OTC)
- Nicotine lozenge OTC (e.g., Nicorette lozenge-OTC)

**OR**

**3.2** History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance)

- Nicotine replacement patches OTC (over the counter) (e.g., Nicoderm CQ-OTC)
- Nicotine gum OTC (e.g., Nicorette gum-OTC)
- Nicotine lozenge OTC (e.g., Nicorette lozenge-OTC)

**AND**

**4** - ONE of the following:

**4.1** Failure to bupropion as confirmed by claims history or submission of medical records

**OR**

**4.2** History of contraindication or intolerance to bupropion (please specify contraindication or intolerance)

Notes

\*Authorization will be issued for 6 months, not to exceed 180 days of therapy per 12 months.

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Colchicine



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512222
<b>Guideline Name</b>	Colchicine
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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**1 . Criteria**

Product Name:colchicine tablets	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of Familial Mediterranean Fever (FMF)</p> <p style="text-align: center;"><b>AND</b></p>	

2 - The patient is 4 years of age or older

Product Name:colchicine tablets	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of Familial Mediterranean Fever (FMF)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The patient's dose is less than or equal to 2.4 mg (milligrams) daily (120 tablets/30 days)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Documentation that the patient had an inadequate response to 1.8 mg daily (90 tablets/30 days)</p>	

Product Name:colchicine tablets	
Diagnosis	Acute Gout
Approval Length	2 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p>	

1 - The patient has a diagnosis of acute gout (does not require prophylaxis)

**AND**

2 - The patient is 16 years of age or older

**AND**

3 - The patient has had an inadequate response, adverse reaction or contraindication to an NSAID (indomethacin, naproxen, ibuprofen, sulindac, or ketoprofen)

**AND**

4 - The patient has had an inadequate response, adverse reaction or contraindication to a corticosteroid (oral or intra-articular)

Product Name: colchicine tablets, Brand Mitigare, generic colchicine capsules	
Diagnosis	Prophylaxis of Chronic Gout
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The requested medication is being used for prophylaxis of chronic gout</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <ul style="list-style-type: none"> <li>• For tablets, the patient is 16 years of age or older</li> <li>• For capsules, the patient is 18 years of age or older</li> </ul>	

**AND**

**3** - One of the following:

**3.1** Documentation that the patient will be treated with colchicine in combination with allopurinol, Uloric (febuxostat), or probenecid

**OR**

**3.2** Documentation that the patient will be treated with colchicine monotherapy and both of the following:

- The patient has had an inadequate response to allopurinol at a dose of 600 mg/day (milligrams per day) for at least two weeks or had an adverse reaction or contraindication to allopurinol
- The patient has had an inadequate response to Uloric (febuxostat) at a dose of 80 mg/day for at least two weeks or has had an adverse reaction or contraindication to Uloric (febuxostat)

**AND**

**4** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Colony Stimulating Factors



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512223
<b>Guideline Name</b>	Colony Stimulating Factors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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**1 . Criteria**

Product Name: Granix, Nyvepria, Neupogen, Fulphila, Leukine, Neulasta, Nivestym, Releuko, Udenyca, Zarxio, Ziextenzo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Used for an FDA-approved indication</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - If used for a diagnosis of nonmyeloid malignancy, ONE of the following:

- The patient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of at least 20%
- The patient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age > 65 years, absolute neutrophil count (ANC) < 100 cells/microliter or the expected duration of neutropenia is > 10 days)
- The patient has experienced a prior episode of febrile neutropenia, and the requested drug will be used as secondary prophylaxis

**AND**

**3** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Compounded Medications



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-423188
<b>Guideline Name</b>	Compounded Medications
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Compounded Medications	
Approval Length	6 months, unless the provider requests for a shorter length of therapy
Guideline Type	Administrative
<p><b>Approval Criteria</b></p> <p>1 - Each active ingredient in the compounded medication is FDA (Food and Drug Administration)-approved or national compendia supported for the condition being treated</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The therapeutic amounts and combinations are supported by national compendia or peer-reviewed literature for the condition being treated in the requested route of delivery

**AND**

**3** - If any prescription ingredients require PA (prior authorization) and/or step therapy, all drug specific criteria have been met

**AND**

**4** - The compounded medication is NOT being used for cosmetic purpose

**AND**

**5** - The compounded medication does NOT include any ingredient that has been withdrawn or removed from the market due to safety reasons (drugs withdrawn from the market due to safety or effectiveness)

**AND**

**6** - One of the following:

**6.1** The patient has tried and failed therapy or had an intolerance to at least two FDA-approved, commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound

**OR**

**6.2** One of the following:

- The patient has a contraindication to commercially available products
- One or no other therapeutic alternatives are commercially available
- Compound medication is prepared in a different dosage form for a recipient who is unable to take the commercially available formulation (mixing or reconstituting commercially available products based on the manufacturer's instructions or the product's approved labeling does not meet this criteria)

- The patient has an allergy or sensitivity to inactive ingredients (e.g., dyes, preservatives, sugars, etc.) that are found in commercially available products

## 2 . Revision History

Date	Notes
10/16/2025	New guideline

Corlanor (ivabradine)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422507
<b>Guideline Name</b>	Corlanor (ivabradine)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Brand Corlanor, generic ivabradine	
Approval Length	Approval length will be based on the appropriate use for the individual agents, not to exceed 12 months
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of chronic heart failure</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has a left ventricular ejection fraction (LVEF) less than or equal to 35%

**AND**

**3** - Patient has a resting heart rate greater than or equal to 70 bpm (beats per minute)

**AND**

**4** - The patient is greater than or equal to 18 years of age

**AND**

**5** - The prescriber is a cardiologist or there is documentation that a cardiologist has been consulted regarding the diagnosis and treatment recommendations

**AND**

**6** - The patient is in a normal sinus rhythm

**AND**

**7** - The patient is on a maximally tolerated dose of a beta-blocker or the recipient has a contraindication to beta-blocker use

## 2 . Revision History

Date	Notes
10/21/2025	New guideline

Crenessity



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439190
<b>Guideline Name</b>	Crenessity
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Crenessity
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency

**AND**

**2** - Diagnosis confirmed by one of the following:

- Pretreatment serum 17-hydroxyprogesterone (17-OHP) level > 3,000 ng/dL
- Cosyntropin stimulation 17OHP level > 10,000 ng/dL
- Genetic variant in CYP21A2 gene

**AND**

**3** - Patient is 4 years of age or older

**AND**

**4** - Chronic treatment with a supraphysiologic glucocorticoid (GC) regimen (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone) defined as ONE of the following:

**4.1** BOTH of the following:

- Patient is 4 to 17 years old
- Daily glucocorticoid dose > 12 mg/m<sup>2</sup> in hydrocortisone dose equivalents

**OR**

**4.2** BOTH of the following:

- Patient is at least 18 years old

<ul style="list-style-type: none"> <li>Daily glucocorticoid dose &gt; 13 mg/m<sup>2</sup>/day in hydrocortisone dose equivalents</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Prescribed by an endocrinologist</p> <p style="text-align: center;"><b>AND</b></p> <p><b>6</b> - If the request is for Crenessity oral solution, ONE of the following:</p> <p><b>6.1</b> Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:</p> <ul style="list-style-type: none"> <li>Age</li> <li>Oral-motor difficulties</li> <li>Dysphagia</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>6.2</b> Patient utilizes a feeding tube for medication administration</p>
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Product Name:Crenessity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Crenessity therapy (e.g., reduction in total glucocorticoid daily dose, decreased androstenedione levels)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient will continue to receive concomitant glucocorticoid replacement (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone)</p>	

**AND**

**3** - Prescribed by an endocrinologist

**AND**

**4** - If the request is for Crenessity oral solution, ONE of the following:

**4.1** Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

**OR**

**4.2** Patient utilizes a feeding tube for medication administration

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Cuvrior



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-423398
<b>Guideline Name</b>	Cuvrior
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Cuvrior	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of Wilson's Disease (defined by a prior or current Leipzig score of greater than or equal to 4)

**AND**

**3** - Both of the following:

**3.1** Patient is being treated with penicillamine for at least 1 year at a stable dose and regimen for at least 4 months

**AND**

**3.2** Patient is tolerating penicillamine and adequately controlled (e.g., serum non-ceruloplasmin copper [NCC] level greater than or equal to 25 and less than or equal to 150 mcg/L or 24-hour urinary copper excretion [UCE] of levels greater than or equal to 100 and less than or equal to 900 mcg/24 hours);

**AND**

**4** - Penicillamine will be discontinued before initiating Cuvrior

**AND**

**5** - Patient will not concurrently use another formulation of trientine (e.g., Syprine, generic trientine)

**AND**

**6** - Prescribed by or in consultation with a hepatologist or neurologist

**AND**

**7** - Daily dose does not exceed 3,000 mg

Product Name:Cuvrior	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient continues to meet the initial criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Evidence of effectiveness of therapy (e.g., as assessed by serum NCC level greater than or equal to 25 and less than or equal to 150 mcg/L or 24-hour UCE levels greater than or equal to 100 and less than or equal to 900 mcg/24 hours)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient does not exhibit clinical manifestations of advancement of Wilson’s Disease from baseline (e.g., jaundice, edema, ascites, esophageal varices, liver failure, CNS symptoms)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Patient has not experienced any treatment-restricting adverse effects (e.g., hypersensitivity reactions, copper deficiency, iron deficiency)</p>	

**2 . Revision History**

Date	Notes
10/22/2025	New

Cystaran, Cystadrops



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439195
<b>Guideline Name</b>	Cystaran, Cystadrops
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Cystaran, Cystadrops	
Diagnosis	Cystinosis

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Approval Length	12 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b> 1 - Diagnosis of cystinosis	

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Cystic Fibrosis Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-398299
<b>Guideline Name</b>	Cystic Fibrosis Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Kalydeco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of cystic fibrosis (CF)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is age appropriate according to the FDA-approved package labeling

**AND**

**3** - Documentation that the patient has had an FDA-approved CF mutation test confirming the presence of one of the gene mutations listed in the FDA-approved package insert

**AND**

**4** - Prescribed by or in consultation with a pulmonologist or a specialist affiliated with a CF care center

Product Name:Kalydeco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of a positive clinical response to therapy	

Product Name:Orkambi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Diagnosis of cystic fibrosis (CF)	
<b>AND</b>	

**2** - Patient is age appropriate according to the FDA-approved package labeling

**AND**

**3** - The patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene

**AND**

**4** - If the request is for Orkambi tablets, ONE of the following:

- The requested dose is two tablets every 12 hours
- The requested dose is one tablet every 12 hours in the presence of severe hepatic impairment

Product Name: Symdeko	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of cystic fibrosis (CF)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is age appropriate according to the FDA-approved package labeling</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by or in consultation with either a pulmonologist or a specialist associated with a CF care center</p>	

**AND**

**4 - ONE of the following:**

- The patient is homozygous for the F508del mutation as detected by an FDA cleared CF mutation test or Clinical Laboratory Improvement Amendments (CLIA) approved facility
- The patient has one of the FDA approved package insert listed mutations on at least one allele in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA cleared CF mutation test or CLIA approved facility

Product Name: Symdeko	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of a positive clinical response to therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations)</p>	

Product Name: Trikafta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of cystic fibrosis (CF)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is age appropriate according to the FDA-approved package labeling

**AND**

**3** - The patient has at least one F508del mutation in the CF transmembrane conductance regulator (CFTR) gene or a mutation in the CFTR gene that is responsive based on in vitro data as detected by an FDA cleared CF mutation test, or a test performed at a Clinical Laboratory Improvement Amendments (CLIA) approved facility

**AND**

**4** - Prescribed by or in consultation with either a pulmonologist or a specialist affiliated with a CF care center

Product Name: Trikafta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of a positive clinical response to therapy (e.g. improvement in lung function [percent predicted FEV1 {PPFEV1}] or decreased number of pulmonary exacerbations)</p>	

Product Name: Alyftrek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of cystic fibrosis (CF)</p>	

**AND**

**2** - Patient is age appropriate according to the FDA-approved package labeling

**AND**

**3** - The patient has at least one F508del mutation or another responsive mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA-cleared CF mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility

**AND**

**4** - The patient does NOT have moderate or severe hepatic impairment (Child-Pugh class B or C)

**AND**

**5** - Prescriber attests that liver function tests are being monitored per FDA package-insert (i.e., prior to initiating therapy, every month for the first six months, every three months for next 12 months, then at least annually)

**AND**

**6** - Prescribed by, or in consultation with, a pulmonologist or a specialist affiliated with a CF care center

Product Name:Alyftrek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - Documentation of positive response to therapy

**AND**

2 - Prescribed by, or in consultation with, a pulmonologist or a specialist affiliated with a CF care center

## 2 . Revision History

Date	Notes
9/22/2025	New program

Daliresp (roflumilast) and Ohtuvayre (ensifentrine)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-398208
<b>Guideline Name</b>	Daliresp (roflumilast) and Ohtuvayre (ensifentrine)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic obstructive pulmonary disease (COPD)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - History of COPD exacerbations</p>	

**AND**

**3** - History of failure, intolerance, or contraindication to ALL of the following:

- Long-acting anticholinergic agent
- Long-acting beta agonist
- Inhaled corticosteroid

**AND**

**4** - Patient does NOT have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment

**AND**

**5** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Ohtuvayre	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of chronic obstructive pulmonary disease (COPD)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - History of COPD exacerbations</p> <p style="text-align: center;"><b>AND</b></p>	

**3** - History of failure, intolerance, or contraindication to ALL of the following:

- Long-acting anticholinergic agent
- Long-acting beta agonist
- Inhaled corticosteroid

**AND**

**4** - If the patient has hepatic impairment, the prescriber attests that Ohtuvayre will be used with caution

**AND**

**5** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

## 2 . Revision History

Date	Notes
9/16/2025	New program

Daraprim



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439197
<b>Guideline Name</b>	Daraprim
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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## 1 . Criteria

Product Name: Brand Daraprim, generic pyrimethamine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Submission of medical records (e.g., chart notes) documenting ONE of the following:</p>	

**1.1** Treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis

**OR**

**1.2** Treatment of congenital toxoplasmosis

**OR**

**1.3** Secondary prophylaxis of toxoplasmic encephalitis

**OR**

**1.4** ALL of the following:

**1.4.1** Primary Pneumocystis pneumonia (PCP) prophylaxis in human immunodeficiency virus (HIV)-infected patients or as secondary prophylaxis in HIV-infected patients who have been treated for an acute episode of Pneumocystis pneumonia

**AND**

**1.4.2** Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

**AND**

**1.4.3** ONE of the following:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate
- Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)

**OR**

**1.5** ALL of the following:

**1.5.1** Primary prophylaxis of toxoplasmic encephalitis

**AND**

**1.5.2** Toxoplasma immunoglobulin G (IgG) positive

**AND**

**1.5.3** CD4 count less than or equal to 100 cells per mm<sup>3</sup> if initiating prophylaxis, or CD4 count 100-200 cells per mm<sup>3</sup> if reinstating prophylaxis\*

**AND**

**1.5.4** Will be used in combination with dapsone or atovaquone

**AND**

**1.5.5** Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

**AND**

**1.5.6** ONE of the following:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate
- Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)

Notes	*Consider discontinuation of primary prophylaxis if CD4 count greater than 200 cells/mm <sup>3</sup> for greater than 3 months after institution of combination antiretroviral therapy.
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## 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/5/2025	Added Nevada Formulary

Daybue (trofinetide)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422505
<b>Guideline Name</b>	Daybue (trofinetide)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Daybue	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is two years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has a diagnosis of typical Rett Syndrome, and a documented MECP2 gene mutation confirmed by genetic testing

**AND**

**3** - Prescribed by or in consultation with neurologist, geneticist, or developmental pediatrician

**AND**

**4** - Prescriber has assessed baseline disease severity of behavior and/or functionality using an objective measure or tool (e.g., Clinical Global Impression-Improvement [CGI-I] score, Motor-Behavior Assessment [MBA], Interval History Form, Clinical Severity Scale, Rett Syndrome Gross Motor Scale)

**AND**

**5** - The patient does not have progressive weight loss prior to initiation of therapy

**AND**

**6** - The patient does not have moderate or severe renal impairment (e.g., estimated glomerular filtration rate (eGFR) less than 45 mL/min/1.73m<sup>2</sup>)

Product Name:Daybue	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - The patient continues to meet the initial authorization criteria	

**AND**

**2** - The patient must have response to therapy from pre-treatment baseline with disease stability or improvement in core symptoms as evidenced on objective measure or tool (e.g., Rett Syndrome Behavior Questionnaire [RSBQ], CGI-I, MBA, Interval History Form, Clinical Severity Scale, Rett Syndrome Gross Motor scale)

**AND**

**3** - The patient has not experienced any treatment-restricting adverse effects (e.g., severe diarrhea or dehydration, significant weight loss)

## 2 . Revision History

Date	Notes
10/21/2025	1/1/2026 Implementation

DEKAs Plus



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-435253
<b>Guideline Name</b>	DEKAs Plus
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:DEKAs Plus Ocean, DEKAs Plus	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of cystic fibrosis

**2 . Revision History**

Date	Notes
11/4/2025	Combined formularies - added NV, VA, NM. No clinical changes.

Diabetic Supply Program



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512224
<b>Guideline Name</b>	Diabetic Supply Program
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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**1 . Criteria**

Product Name: Insulin pumps and patches (all brands)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a documented diagnosis of DM1 (diabetes mellitus type I) or Gestational Diabetes</p>	

**AND**

**2** - The requested product must be prescribed by, or in consultation with, an endocrinologist

**AND**

**3** - The patient meets all age restrictions stated in the manufacturer's label

**AND**

**4** - The patient must have been compliant on their current antidiabetic regimen for at least the last six months and the requested regimen must include multiple day injections of insulin (requiring at least three injections per day)

**AND**

**5** - One of the following

**5.1** Documented history of recurring hypoglycemia

**OR**

**5.2** Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL (milligrams per deciliter)

**OR**

**5.3** Prior use of an insulin pump with documented frequency of glucose self-testing of at least four times per day in the month immediately prior to the request

**AND**

**6** - If the request is non-preferred\*, one of the following:

**6.1** The patient must have one of the following reasons/special circumstances:

- The patient has had an allergic reaction to a preferred product or related supply
- The patient has a visual impairment which requires the use of a non-preferred product
- The patient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product

**OR**

**6.2** Both of the following:

- The patient must have been trained to use the non-preferred product
- The patient must have benefited from use of the non-preferred product

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Insulin pumps and patches (all brands)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has documented positive clinical response to the product, including current HbA1C (hemoglobin A1C) (please document date of last HbA1C and value)</p>	

Product Name: Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a documented diagnosis of DM1 (diabetes mellitus type I), DM2 (diabetes mellitus type 2) or Gestational Diabetes</p>	

**AND**

**2** - The patient meets all age restrictions stated in the manufacturer's label

**AND**

**3** - The patient must have been compliant on their current antidiabetic regimen for at least the last six months and the requested regimen must include multiple day injections of insulin (requiring at least three injections per day)

**AND**

**4** - One of the following

**4.1** Documented history of recurring hypoglycemia

**OR**

**4.2** Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL (milligrams per deciliter)

**OR**

**4.3** The patient is currently using insulin pump therapy while continuing to need frequent dosage adjustments or experiencing recurring episodes of severe hypoglycemia [50 mg/dL (milligrams per deciliter)]

**AND**

**5** - If the request is non-preferred\*, one of the following:

**5.1** The patient must have one of the following reasons/special circumstances:

- The patient has had an allergic reaction to a preferred product or related supply
- The patient has a visual impairment which requires the use of a non-preferred product

<ul style="list-style-type: none"> <li>The patient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>5.2</b> Both of the following:</p> <ul style="list-style-type: none"> <li>The patient must have been trained to use the non-preferred product</li> <li>The patient must have benefited from use of the non-preferred product</li> </ul>	
Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Dojolvi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439199
<b>Guideline Name</b>	Dojolvi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Dojolvi
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Submission of medical records confirming the diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) with at least two of the following diagnostic criteria:

- Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma
- Low enzyme activity in cultured fibroblasts
- Genetic testing demonstrating one or more pathogenic mutations in a gene associated with long-chain fatty acid oxidation disorders (e.g., CPT2, ACADVL, HADHA, or HADHB)

**AND**

**2** - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products

**AND**

**3** - Prescribed by a board-certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

**AND**

**4** - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

**AND**

**5** - Patient is receiving disease related dietary management

**AND**

**6** - If not diagnosed by newborn screening, patient has a history of clinical manifestations of long-chain fatty acid oxidation disorders LC-FAOD (e.g., rhabdomyolysis)

Product Name:Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Dojolvi therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) product</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by a board-certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Patient is receiving disease related dietary management</p>	

## 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/5/2025	Added Nevada Formulary

Doptelet



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439201
<b>Guideline Name</b>	Doptelet
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Doptelet	
Diagnosis	Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure
Approval Length	1 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of thrombocytopenia</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has chronic liver disease</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient is scheduled to undergo a procedure</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Failure to Mulpleta (lusutrombopag) as confirmed by claims history or submission of medical records</li> <li>• History of contraindication or intolerance to Mulpleta (lusutrombopag) (please specify contraindication or intolerance)</li> </ul>	

Product Name:Doptelet	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic immune thrombocytopenia (ITP)</p>	

**AND**

**2 - ONE of the following:**

**2.1 BOTH of the following:**

**2.1.1 ONE of the following:**

**2.1.1.1** Failure to at least ONE of the following as confirmed by claims history or submission of medical records:

- Corticosteroids
- Immunoglobulins

**OR**

**2.1.1.2** History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Corticosteroids
- Immunoglobulins

**AND**

**2.1.2 ONE of the following:**

- Failure to eltrombopag olamine (generic Promacta) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to eltrombopag olamine (generic Promacta) (please specify contraindication or intolerance)

**OR**

**2.2** Patient is currently on Doptelet therapy

Product Name:Doptelet	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Doptelet therapy</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Doxepin Topical



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-416248
<b>Guideline Name</b>	Doxepin Topical
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Prudoxin, Brand Zonalon, generic doxepin cream	
Approval Length	8 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of pruritus with atopic dermatitis or lichen simplex chronicus</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient is 18 years of age or older</p>	

**AND**

**3** - Treatment will not exceed 8 days

## **2 . Revision History**

Date	Notes
10/7/2025	New guideline

Duchenne Muscular Dystrophy (DMD) Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-504221
<b>Guideline Name</b>	Duchenne Muscular Dystrophy (DMD) Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Exondys 51	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - There is documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**AND**

**4** - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight once weekly

Product Name: Exondys 51	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is tolerating therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight once weekly</p>	

**AND**

**4** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

Product Name: Brand Emflaza, generic deflazacort, Jaythari, Pyquvi, Kymbee	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

**AND**

**2** - The patient is 5 years of age or older

**AND**

**3** - The patient has received genetic testing for a mutation of the dystrophin gene, and one of the following:

- Documentation of a confirmed mutation of the dystrophin gene
- Muscle biopsy confirming an absence of dystrophin protein

**AND**

**4** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**AND**

**5** - The patient has had at least a three-month trial and failure of prednisone (prednisolone or equivalent dose) or a documented intolerance to prednisone (prednisolone or equivalent dose) given at a dose of 0.75 mg/kg/day (milligrams per kilogram per day) or 10 mg/kg/week

**AND**

**6** - The prescribed dose does not exceed 0.9 mg per kg of body weight once daily

Product Name: Brand Emflaza, generic deflazacort, Jaythari, Pyquvi, Kymbee

Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Documentation of positive clinical response to the requested therapy (e.g., improvement or preservation of muscle strength)

**AND**

**2** - The prescribed dose does not exceed 0.9 mg per kg of body weight once daily

Product Name: Vyondys 53

Approval Length	6 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Submission of medical records (e.g., chart notes, laboratory values) confirming the following:

**1.1** The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

**AND**

**1.2** Mutation of the dystrophin gene amenable to exon 53 skipping

**AND**

**2** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**AND**

**3** - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly

Product Name:Vyondys 53	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - One of the following:

**1.1** If the patient has been on therapy for less than 12 months, all of the following:

- The patient is tolerating therapy
- The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly
- The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**OR**

**1.2** If the patient has been on therapy for 12 months or more, all of the following:

- The patient experienced a benefit from therapy (e.g. disease amelioration compared to untreated patients)
- The patient is tolerating therapy
- The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly
- The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

Product Name: Viltepso	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Submission of medical records (e.g., chart notes, laboratory values) confirming the following:</p> <p>1.1 The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 Mutation of the dystrophin gene amenable to exon 53 skipping</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The prescribed dose does not exceed 80 mg (milligrams) per kg (kilogram) of body weight infused once weekly</p>	

Product Name:Viltepso	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 If the patient has been on therapy for less than 12 months, all of the following:</p> <ul style="list-style-type: none"> <li>• The patient is tolerating therapy</li> <li>• The prescribed dose does not exceed 80 mg (milligrams) per kg (kilogram) of body weight infused once weekly</li> <li>• The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>1.2 If the patient has been on therapy for 12 months or more, all of the following:</p> <ul style="list-style-type: none"> <li>• The patient experienced a benefit from therapy (e.g. disease amelioration compared to untreated patients)</li> <li>• The patient is tolerating therapy</li> <li>• The prescribed dose does not exceed 80 mg (milligrams) per kg (kilogram) of body weight infused once weekly</li> <li>• The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children</li> </ul>	

Product Name:Amondys 45	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p>	

**1** - Submission of medical records (e.g., chart notes, laboratory values) confirming the following:

**1.1** The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

**AND**

**1.2** Mutation of the dystrophin gene amenable to exon 45 skipping

**AND**

**2** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**AND**

**3** - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly

Product Name:Amondys 45	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient is tolerating therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly</p>	

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

Product Name:Elevidys	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Submission of medical records (e.g., chart notes, laboratory values) confirming the following:</p> <p><b>1.1</b> The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2</b> The patient has mutation of the DMD gene</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.3</b> The patient does not have any deletion in exon 8 and/or exon 9 in the DMD gene</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.4</b> The patient has a baseline anti-AAVrh74 total binding antibody titer of less than 1,400 as measured by enzyme-linked immunosorbent assay (ELISA)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is 4 years of age or older</p>	

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a pediatric neuromuscular specialist with advanced knowledge in treating DMD

**AND**

**4** - The patient is NOT on concomitant therapy with DMD-directed antisense oligonucleotides (e.g., golodirsen, casimersen, viltolarsen, eteplirsen)

**AND**

**5** - The patient does NOT have an active infection, including clinically important localized infections

**AND**

**6** - The patient has been on a stable dose of corticosteroid, unless contraindicated or intolerance, prior to start of therapy and will be used concomitantly with a corticosteroid regimen pre- and post-infusion

**AND**

**7** - The patient's troponin-I levels will be monitored at baseline and subsequently as clinically indicated

**AND**

**8** - The patient will have liver function assessed prior to and following therapy for at least three months as indicated

**AND**

**9** - The patient is receiving physical and/or occupational therapy

**AND**

**10** - The patient has never previously received Elevidys treatment in their lifetime

Product Name:Agamree	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient is 2 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The patient has had at least one of the following:</p> <p><b>4.1</b> At least six month trial and failure of prednisone (prednisolone or equivalent dose) at dose of 0.75 mg/kg/day (milligrams per kilogram per day)</p> <p style="text-align: center;"><b>OR</b></p>	

**4.2** Documented history of intolerable adverse events, hypersensitivity, or contraindication to prednisone (prednisolone or equivalent dose)

**AND**

**5** - The requested medication is dosed per FDA (Food and Drug Administration)-label based on patient weight [up to a maximum daily dosage of 300 mg (milligrams) for patients weighing more than 50 kg (kilogram)]

Product Name:Agamree

Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Patient is 2 years of age or older

**AND**

**2** - Diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**AND**

**4** - The requested medication is dosed per FDA (Food and Drug Administration)-label based on patient weight [up to a maximum daily dosage of 300 mg (milligrams) for patients weighing more than 50 kg (kilogram)]

**AND**

**5** - Documentation of positive clinical response to therapy

Product Name: Duvyzat

Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - The patient is 6 years of age or older

**AND**

**2** - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin

**AND**

**3** - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

**AND**

**4** - The requested medication will be used in combination with a corticosteroid (i.e., prednisone) unless contraindicated or not tolerated

**AND**

**5** - Platelets are greater than or equal to  $150 \times 10^9$ /liter prior to initiation

**AND**

**6** - The requested medication will be dosed per FDA (Food and Drug Administration)-label based on patient body weight [maximum dose of 53.2 mg (milligrams) twice daily]

Product Name:Duvyzat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient is 6 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The requested medication will be used in combination with a corticosteroid (i.e., prednisone) unless contraindicated or not tolerated</p> <p style="text-align: center;"><b>AND</b></p>	

**5** - The requested medication will be dosed per FDA (Food and Drug Administration)-label based on patient body weight [maximum dose of 53.2 mg (milligrams) twice daily]

**AND**

**6** - Patient has NOT experienced any treatment-restricting adverse effects (e.g., hematological changes such as thrombocytopenia or other signs of myelosuppression, hypertriglyceridemia, severe-gastrointestinal disturbances, and/or QTc prolongation)

**AND**

**7** - Documentation of positive clinical response to therapy

## 2 . Revision History

Date	Notes
1/21/2026	Updated GPs. Added Kymbee

Egrifta



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-438202
<b>Guideline Name</b>	Egrifta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Egrifta SV, Egrifta WR	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy</p>	

## 2 . Revision History

Date	Notes
11/5/2025	Added Egrifta WR. Added NV formulary.

Ekterly



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-461195
<b>Guideline Name</b>	Ekterly
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Ekterly	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

**1.1** C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

**OR**

**1.2** HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiotensin-converting enzyme 1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosaminase 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

**AND**

**2** - Prescribed for the acute treatment of HAE attacks

**AND**

**3** - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir)

**AND**

**4** - Prescribed by ONE of the following:

- Immunologist
- Allergist

Product Name:Ekterly	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Ekterly therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed for the acute treatment of HAE (hereditary angioedema) attacks</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Immunologist</li> <li>• Allergist</li> </ul>	

## 2 . Revision History

Date	Notes
12/8/2025	No changes to criteria. Inactivated GL-439202 for 1/1/26, due to formulary changes. Removed VA and MI. Added IN. GL-461195 for 1/1/26 with correct formularies.



Elfabrio



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422498
<b>Guideline Name</b>	Elfabrio
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Elfabrio	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has a documented diagnosis of Fabry disease ( $\alpha$  -galactosidase A [ $\alpha$ -Gal A] deficiency) with biochemical/genetic confirmation by one of the following:

- $\alpha$ -Gal-A activity in plasma, isolated leukocytes, and/or cultured cells (males only)
- Detection of pathogenic mutations in the galactosidase alpha (GLA) gene by molecular genetic testing

**AND**

**3** - Prescribed by or in consultation with a neurologist, geneticist, or other specialist with advanced knowledge in treating Fabry disease

**AND**

**4** - The patient must have a baseline value for plasma GL-3 and/or GL-3 inclusions, plasma or urinary globotriaosylceramide (Gb3/GL-3); or plasma globotriaosylsphingosine (lyso- Gb3)

**AND**

**5** - Patient must not be taking migalastat (Galafold) or agalsidase beta (Fabrazyme) during pegunigalsidase alfa-iwxj (Elfabrio) therapy

**AND**

**6** - Medication is dosed per FDA labeling of 1 mg/kg (based on actual body weight) administered by IV infusion every two weeks

Product Name:Elfabrio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - The patient continues to meet the initial authorization criteria

**AND**

2 - Patient must have experienced a disease response with treatment as defined by a reduction or stabilization in greater than or equal to 1 of the following, as compared to pre-treatment baseline:

- plasma GL-3 and/or GL-3 inclusions
- plasma or urinary Gb3/GL-3
- plasma lyso-Gb3

**AND**

3 - The patient must have experienced a disease response with treatment as defined by an improvement or stabilization in the rate of decline of the eGFR

**AND**

4 - The patient has not experienced unacceptable toxicity from the drug (e.g., anaphylaxis and severe hypersensitivity reactions, severe infusion-associated reactions, glomerulonephritis).

## 2 . Revision History

Date	Notes
10/21/2025	1/1/2026 Implementation

Elmiron



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-435262
<b>Guideline Name</b>	Elmiron
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Elmiron	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient has a documented diagnosis of bladder pain or discomfort associated with interstitial cystitis

**2 . Revision History**

Date	Notes
11/4/2025	Combined formularies - added NV, VA, NE, NM, PA CAID. No clinical changes.

Empaveli



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-443192
<b>Guideline Name</b>	Empaveli
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Empaveli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:</b></p> <p><b>1.1 Flow cytometry analysis confirming presence of PNH clones</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2 Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <p><b>2.1 Patient will not be prescribed Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2 Patient is currently receiving another complement inhibitor (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) which will be discontinued and Empaveli will be initiated in accordance with the United States Food and Drug Administration approved labeling</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - Prescribed by, or in consultation with, ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Hematologist</li> <li>• Oncologist</li> </ul>	

Product Name:Empaveli	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Empaveli therapy [e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH (lactate dehydrogenase), increased reticulocyte count, etc.]</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by, or in consultation with, ONE of the following:</p> <ul style="list-style-type: none"> <li>• Hematologist</li> <li>• Oncologist</li> </ul>	

Product Name:Empaveli	
Diagnosis	C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p>	

**1 - One of the following:**

**1.1 All of the following:**

**1.1.1** Diagnosis of immune complex/monoclonal immunoglobulin-mediated Membranoproliferative glomerulonephritis (IC-MPGN)

**AND**

**1.1.2** Confirmation of diagnosis is based on immunofluorescence microscopy on kidney biopsy

**AND**

**1.1.3** All of the following secondary causes of IC-MPGN have been ruled out:

- Infections (e.g., Hepatitis B and hepatitis C virus, chronic bacterial infections, parasitic infections)
- Autoimmune diseases [e.g., systemic lupus erythematosus (SLE), Sjogren's syndrome, rheumatoid arthritis, systemic sclerosis]
- Monoclonal gammopathy

**AND**

**1.1.4** Patient has NOT had a kidney transplant

**OR**

**1.2 All of the following:**

**1.2.1** Diagnosis of complement 3 glomerulopathy (C3G)

**AND**

**1.2.2** Confirmation of diagnosis is based on immunofluorescence microscopy on kidney biopsy

**AND**

**1.2.3** One of the following:

**1.2.3.1** Serum complement 3 (C3) protein less than 77 milligrams per deciliter (alternatively, less than 0.85 x lower limit of the central laboratory normal range)

**OR**

**1.2.3.2** Other complement abnormalities are present [e.g., soluble membrane attack complex (sC5b-9), serum factor H, serum factor B, factor I, membrane cofactor protein (MCP, CD46), C3/C4/C5 nephritic factor (NeF)] which are suggestive of a C3 glomerulopathy

**AND**

**1.2.4** Presence of monoclonal gammopathy of undetermined significance (MGUS) has been excluded by measurement of serum free light chains or other investigative means based on standards of care

**AND**

**2** - Glomerulonephritis has persisted  $\geq$  3 months in duration

**AND**

**3** - Disease is considered to be moderate to severe based on proteinuria greater than or equal to 1.5 grams per day and/or abnormal kidney function

**AND**

**4** - Used to reduce proteinuria

**AND**

**5** - One of the following:

- Failure to a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify contraindication or intolerance)

**AND**

**6** - One of the following:

**6.1** Patient is on a stabilized dose and receiving concomitant therapy with one of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

**OR**

**6.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication or intolerance)

**AND**

**7** - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

**AND**

**8** - Prescribed by or in consultation with a nephrologist

Product Name:Empaveli

Diagnosis

C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Empaveli therapy demonstrated by a reduction in proteinuria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkempv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by, or in consultation with, a nephrologist</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Epysqli to examples of other complement inhibitors. Added criteria for new FDA-approved indications C3G and IC-MPGN. Added N V formulary.

Entresto (sacubitril-valsartan)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422540
<b>Guideline Name</b>	Entresto (sacubitril-valsartan)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Entresto, generic sacubitril/valsartan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of chronic heart failure New York Heart Association (NYHA) Class II to IV</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has reduced LVEF (left ventricular ejection fraction)

**AND**

**3** - The patient is one year of age or older

**AND**

**4** - The prescriber is a cardiologist or there is documentation that a cardiologist has been consulted

**AND**

**5** - The patient has had a trial of an angiotensin converting enzyme (ACE) or an angiotensin receptor blocker (ARB) for at least four weeks prior to the initiation of therapy

**AND**

**6** - The patient will NOT concurrently receive an ACE inhibitor

**AND**

**7** - The patient is on an individualized dose of a beta blocker, or the patient has a contraindication to beta blocker use

**AND**

**8** - The requested dose will not exceed 97/103 mg twice daily

**AND**

**9** - If the request is for sprinkle capsules, there is documentation of a clinical reason why the patient cannot safely take tablets (e.g., difficulty swallowing) (please document reasoning)

## 2 . Revision History

Date	Notes
10/22/2025	New guideline

Esbriet, Ofev



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439204
<b>Guideline Name</b>	Esbriet, Ofev
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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## 1 . Criteria

Product Name: Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) as documented by ALL of the following:</b></p> <p><b>1.1</b> Exclusion of other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), as documented by an ICD-10 Code of J84.112 (idiopathic pulmonary fibrosis)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2 ONE</b> of the following:</p> <p><b>1.2.1</b> If the patient was NOT subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2.2</b> If the patient was subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE</b> of the following:</p> <p><b>2.1</b> If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - The prescriber is a pulmonologist</b></p>	

Product Name: Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to the requested therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)</p>	

Product Name: Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following:</p> <p>1.1 ONE of the following:</p>	

**1.1.1** Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

**OR**

**1.1.2** At least TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud’s phenomenon
- SSc-related autoantibodies [e.g., anticentromere, anti-topoisomerase I, anti-RNA (ribonucleic acid) polymerase III]

**AND**

**1.2** Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on high-resolution computed tomography (HRCT), involving at least 10% of the lungs

**AND**

**2** - Ofev is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Product Name:Ofev	
Diagnosis	Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following:

**1.1** Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

**AND**

**1.2** Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

**1.2.1** Forced vital capacity (FVC) decline of greater than 10%

**OR**

**1.2.2** TWO of the following:

- FVC decline of greater than or equal to 5%, but less than 10%
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

**AND**

**2** - Ofev is not being used in combination with Esbriet (pirfenidone)

**AND**

**3** - The prescriber is a pulmonologist

Product Name:Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease, Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Ofev therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Ofev is not being used in combination with Esbriet (pirfenidone)</p>	

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Evkeeza (evinacumab-dgnb)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422545
<b>Guideline Name</b>	Evkeeza (evinacumab-dgnb)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Evkeeza	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is at least 5 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Prescribed by or in consultation with a specialist in cardiology, lipidology, or endocrinology

**AND**

**3** - The patient has a confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) by ONE of the following:

**3.1** Documented DNA test for functional mutation(s) in low density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality

**OR**

**3.2** ALL of the following:

- Untreated LDL cholesterol (LDL-C) levels greater than 500 mg/dL or treated LDL-C greater than or equal to 300 mg/dL
- Cutaneous or tendon xanthoma before 10 years of age
- Untreated LDL-C levels in both parents consistent with heterozygous familial hypercholesterolemia (HeFH)

**AND**

**4** - The patient does not have HeFH

**AND**

**5** - Submission of baseline LDL-C, total cholesterol (TC), apolipoprotein B (apo B), and non-high density lipoprotein cholesterol (non-HDL-C) labs prior to initiating treatment

**AND**

**6** - The patient has been receiving stable background lipid lowering therapy for greater than or equal to 4 weeks

**AND**

**7** - Therapy will be used in conjunction with diet and other LDL-lowering therapies (e.g., statins, ezetimibe, PCSK9 inhibitors, lomitapide, LDL apheresis)

**AND**

**8** - The patient has tried and failed at least a three-month trial of adherent therapy with ezetimibe used in combination with the highest available or maximally tolerated dose of atorvastatin or rosuvastatin, unless contraindication to statin or ezetimibe

**AND**

**9** - The patient has tried and failed at least a three-month trial of adherent therapy with combination therapy consisting of the highest available or maximally tolerated dose of atorvastatin or rosuvastatin, ezetimibe, and a PCSK9 inhibitor indicated for HoFH (i.e., evolocumab), unless contraindicated

**AND**

**10** - Despite pharmacological treatment with a PCSK9 inhibitor, statin, and ezetimibe, the patient’s LDL-C is greater than or equal to 100 mg/dL or greater than or equal to 70 mg/dL for recipients with clinical atherosclerotic cardiovascular disease

**AND**

**11** - If the patient is female, must have a negative pregnancy test and have been counseled to use effective contraception during treatment

Product Name:Evkeeza	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1** - Prescribed by or in consultation with a specialist in cardiology, lipidology, or endocrinology

**AND**

**2** - The patient has had a documented reduction in LDL-C when compared to the initial baseline labs

**AND**

**3** - The patient continues to adhere to diet and background lipid lowering therapy (e.g., statin, ezetimibe, PCSK9 inhibitor)

## 2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Fabhalta



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439205
<b>Guideline Name</b>	Fabhalta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Fabhalta	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:</p> <p><b>1.1</b> Flow cytometry analysis confirming presence of PNH clones</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2</b> Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - ONE of the following:</p> <p><b>2.1</b> Patient will not be prescribed Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, PiaSky, eculizumab, Ultomiris)</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> Patient is currently receiving another complement inhibitor (e.g., Empaveli, PiaSky, eculizumab, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the United States Food and Drug Administration approved labeling</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by, or in consultation with, ONE of the following:</p> <ul style="list-style-type: none"> <li>• Hematologist</li> <li>• Oncologist</li> </ul>	

Product Name:Fabhalta	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Fabhalta therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is not receiving Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, PiaSky, eculizumab, Ultomiris)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by, or in consultation with, ONE of the following:</p> <ul style="list-style-type: none"> <li>• Hematologist</li> <li>• Oncologist</li> </ul>	

Product Name:Fabhalta	
Diagnosis	Primary immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy</p>	

**AND**

**2** - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

**AND**

**3** - Used to reduce proteinuria

**AND**

**4** - Estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m<sup>2</sup>

**AND**

**5** - ONE of the following:

**5.1** Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

**OR**

**5.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

**AND**

**6** - ONE of the following:

**6.1** Patient is on a stabilized dose and receiving concomitant therapy with a maximally

tolerated sodium-glucose cotransporter-2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin)] as confirmed by claims history or submission of medical records

**OR**

**6.2** Patient has an allergy, contraindication, or intolerance to SGLT2 inhibitors (please specify allergy, contraindication, or intolerance)

**AND**

**7** - ONE of the following:

**7.1** Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records

**OR**

**7.2** History of intolerance or contraindication to a glucocorticoid (please specify intolerance or contraindication)

**AND**

**8** - Prescribed by or in consultation with a nephrologist

Product Name:Fabhalta	
Diagnosis	Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of complement 3 glomerulopathy (C3G) confirmed by all of the following:</p> <p><b>1.1</b> Documentation of a kidney biopsy demonstrating characteristic findings of C3G</p>	

**AND**

**1.2** Glomerulonephritis has persisted at least 3 months in duration

**AND**

**1.3** ONE of the following:

- Serum complement 3 (C3) protein less than 77 mg/dL (alternatively, less than 0.85 x lower limit of the central laboratory normal range)
- Other complement abnormalities are present [e.g., soluble membrane attack complex (sC5b-9), serum factor H, serum factor B, factor I, membrane cofactor protein (MCP, CD46), C3/C4/C5 nephritic factor (NeF)] which are suggestive of a C3 glomerulopathy

**AND**

**1.4** Presence of monoclonal gammopathy of undetermined significance (MGUS) has been excluded by measurement of serum free light chains or other investigative means based on standards of care

**AND**

**2** - Disease is considered to be moderate to severe based on proteinuria greater than or equal to 1.5 g/day and/or abnormal kidney function

**AND**

**3** - Used to reduce proteinuria

**AND**

**4** - ONE of the following:

- Failure to a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records

- History of intolerance or contraindication to a glucocorticoid (please specify intolerance or contraindication)

**AND**

**5 - ONE of the following:**

**5.1** Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

**OR**

**5.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

**AND**

**6 - Patient has NOT undergone a solid-organ or cell transplant, including kidney transplant**

**AND**

**7 - Prescribed by or in consultation with a nephrologist**

Product Name:Fabhalta	
Diagnosis	Primary immunoglobulin A nephropathy (IgAN), Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to Fabhalta therapy demonstrated by a reduction in proteinuria

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Filsuvez (birch triterpenes)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-391201
<b>Guideline Name</b>	Filsuvez (birch triterpenes)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Filsuvez	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 6 months old</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB) confirmed by genetic testing

**AND**

**3** - Presence of open partial-thickness wounds associated with DEB or JEB for greater than or equal to 21 days

**AND**

**4** - The requested medication will be applied every one to four days with dressing changes

**AND**

**5** - The patient does not have current evidence or history of squamous cell carcinoma (SCC) in the area that will undergo treatment

**AND**

**6** - The patient does not have active infection in the area that will undergo treatment

**AND**

**7** - Will not be used concurrently with Vyjuvek

**AND**

**8** - Prescribed by, or in consultation with, a dermatologist or geneticist

Product Name:Filsuvez	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient continues to meet initial authorization criteria

**AND**

**2** - Documentation of positive response to therapy

Firdapse



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-500236
<b>Guideline Name</b>	Firdapse
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Firdapse	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Diagnosis confirmed by ONE of the following:</p> <p>2.1 Increased compound muscle action potential (CMAP) amplitude after exercise or with high-frequency repetitive nerve stimulation (RNS)</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 A high titer P/Q-type voltage-gated calcium channels (VGCC) antibody</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by or in consultation with a specialist in the treatment of LEMS (e.g., neurologist or oncologist)</p>	

Product Name:Firdapse	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Firdapse therapy (e.g., improved muscle strength, improved mobility)</p>	

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
1/20/2026	Removed IN and PACAID. Updated initial authorization to include confirmation of diagnosis. Removed requirement for no concomitant use with similar potassium channel blockers. Added examples of positive clinical response under reauth criteria.

Functional Gastrointestinal Disorder Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-397228
<b>Guideline Name</b>	Functional Gastrointestinal Disorder Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Linzess	
Diagnosis	Chronic idiopathic constipation (CIC), Function Constipation (FC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of one of the following:

- Chronic idiopathic constipation (CIC)
- Function Constipation (FC) in pediatric recipients

**AND**

**2** - The requested medication must be FDA (Food and Drug Administration)-approved for the patient's age

**AND**

**3** - The patient has trial and failure, contraindication or intolerance to either lactulose or polyethylene glycol (Miralax)

**AND**

**4** - The patient has trial and failure, contraindication or intolerance to at least one stimulant laxative, such as sennosides (Ex-Lax, Senokot), bisacodyl (Dulcolax) or cascara sagrada

**AND**

**5** - The requested dose does not exceed the following:

**5.1** For CIC: 145 mcg (micrograms), once daily

**OR**

**5.2** For FC: 72 mcg, once daily

Product Name: Brand Amitiza, generic lubiprostone, Brand Motegrity, generic prucalopride, Trulance	
Diagnosis	Chronic idiopathic constipation (CIC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1** - The patient has a diagnosis of chronic idiopathic constipation (CIC)

**AND**

**2** - The requested medication must be FDA (Food and Drug Administration)-approved for the patient's age

**AND**

**3** - The patient has trial and failure, contraindication or intolerance to either lactulose or polyethylene glycol (Miralax)

**AND**

**4** - The patient has trial and failure, contraindication or intolerance to at least one stimulant laxative, such as sennosides (Ex-Lax, Senokot), bisacodyl (Dulcolax) or cascara sagrada

**AND**

**5** - The requested dose does not exceed the following:

**5.1** For Amitiza (lubiprostone): 24 mcg (micrograms), twice daily

**OR**

**5.2** For Motegrity (prucalopride): 2 mg (milligrams), once daily

**OR**

**5.3** For Trulance: 2 mg once daily

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Ibsrela, Linzess, Brand Amitiza, generic lubiprostone, Trulance	
Diagnosis	Irritable Bowel Syndrome with constipation
Approval Length	Approval Duration is to be determined based on the requested medication and diagnosis, not to exceed one year
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The requested dose is appropriate based on FDA (Food and Drug Administration) approved indication and age</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - If the request is for Amitiza, the patient is female</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	

Product Name: Brand Lotronex, generic alosetron, Viberzi

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Diagnosis	Irritable Bowel Syndrome with diarrhea
Approval Length	Approval Duration is to be determined based on the requested medication and diagnosis, not to exceed one year
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The requested dose is appropriate based on FDA (Food and Drug Administration) approved indication and age</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - The requested medication is being prescribed by or in consultation with a gastroenterologist</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	

Product Name: Linzess, Brand Amitiza, generic lubiprostone, lbsrela, Motegrity, generic prucalopride, Movantik, Relistor, Symproic, Trulance	
Diagnosis	Opioid-Induced Constipation
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of Opioid-Induced Constipation

**AND**

**2** - The patient is 18 years of age or older

**AND**

**3** - The requested medication is being used for an FDA (Food and Drug Administration) approved indication

**AND**

**4** - Documentation of an inadequate response, adverse reaction, or contraindication to one agent from three of the following four traditional laxative drug classes:

- Bulk forming laxatives
- Osmotic laxatives
- Saline laxatives
- Stimulant laxatives

**AND**

**5** - If the request is for Relistor injection, all of the following:

**5.1** The dose does not exceed 0.15 mg/kg (milligrams per kilogram)

**AND**

**5.2** The patient's current weight is greater than 114 kg

**AND**

**5.3** The patient is not enrolled in The Division of Health Care Financing and Policy's (DHCFP's) hospice program

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

## 2 . Revision History

Date	Notes
10/1/2025	New guideline

Furoscix



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439207
<b>Guideline Name</b>	Furoscix
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Furoscix	
Approval Length	1 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Chronic heart failure</li> <li>• Chronic kidney disease (CKD)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Submission of medical records confirming that the patient is established on background loop diuretic therapy (e.g., bumetanide, furosemide, torsemide) for the treatment of edema</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - BOTH of the following:</b></p> <ul style="list-style-type: none"> <li>• Patient does NOT require ongoing emergency care or hospitalization</li> <li>• Patient is currently a candidate for parenteral diuresis outside of the hospital</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Furoscix is prescribed by or in consultation with ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Cardiologist</li> <li>• Nephrologist</li> </ul>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Galafold



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-435261
<b>Guideline Name</b>	Galafold
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Galafold	
Diagnosis	Fabry Disease
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Fabry disease</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta) or Elfabrio (pegunigalsidase alfa-iwxj)</p>	

Product Name:Galafold	
Diagnosis	Fabry Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Galafold therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta) or Elfabrio (pegunigalsidase alfa-iwxj)</p>	

## 2 . Revision History

Date	Notes
11/4/2025	Combined formularies - added NV, VA, NE, NM, PA CAID. No clinical changes.

Gattex



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439208
<b>Guideline Name</b>	Gattex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Gattex	
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Short Bowel Syndrome (SBS)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Dependent on parenteral support</p>	

Product Name:Gattex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Gattex therapy</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Gimoti (metoclopramide)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-413210
<b>Guideline Name</b>	Gimoti (metoclopramide)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Gimoti	
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of acute diabetic gastroparesis</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is 18 years of age or older

**AND**

**3** - Patient does not have any of the following:

- History of signs or symptoms of tardive dyskinesia (TD)
- History of a dystonic reaction to metoclopramide
- Known or suspected circumstances where stimulation of gastrointestinal (GI) motility could be dangerous (e.g., GI hemorrhage, mechanical obstruction, or perforation)
- Known or suspected pheochromocytoma or other catecholamine-releasing paraganglioma
- Diagnosis of epilepsy or any other seizure disorder
- Hypersensitivity to metoclopramide (e.g., angioedema, bronchospasm)
- Moderate or severe renal impairment (CrCL < 60 mL/minute)
- Moderate or severe hepatic impairment (Child-Pugh B or C)

**AND**

**4** - ONE of the following:

- The patient has had an adequate (e.g., 2-4 week) trial and failure of oral (e.g., tablet, solution, orally disintegrating tablet) or injectable (e.g., IM) metoclopramide
- The patient is not a candidate for oral metoclopramide (e.g., demonstrated or documented erratic absorption of oral medications)

Product Name:Gimoti	
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Patient meets initial authorization criteria	

**AND**

**2** - At least two weeks have passed (i.e., drug holiday) since completion of a previous course or metoclopramide treatment of any dosage form

**AND**

**3** - Patient demonstrated improvement in signs and symptoms of diabetic gastroparesis (e.g., nausea, vomiting, early satiety, postprandial fullness, bloating, upper abdominal pain)

**AND**

**4** - Prescriber attests that the patient is being monitored for extrapyramidal symptoms (e.g., tardive dyskinesia, dystonia) or other serious adverse events (e.g., suicidal ideation, fluid retention)

## 2 . Revision History

Date	Notes
10/7/2025	New program

GnRH Analogs



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-512225
<b>Guideline Name</b>	GnRH Analogs
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/2/2026
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## 1 . Criteria

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Central precocious puberty (CPP)
Approval Length	12 months, or until the member reaches the age of 11 years if female or 12 years if male
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of idiopathic or neurogenic central precocious puberty (CPP)</p>	

**AND**

**2** - The medication is being prescribed by, or in consultation with, a pediatric endocrinologist

**AND**

**3** - There is an onset of secondary sex characteristics before age eight years for females or before nine years for males

**AND**

**4** - The patient is currently less 11 years of age if female, or less than 12 years of age if male

**AND**

**5** - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Gender Dysphoria, formerly known as gender identity disorder
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1** - The patient has a diagnosis of gender dysphoria, formerly known as gender identity disorder

**AND**

**2** - The patient is less than 18 years of age

**AND**

**3** - The medication is being prescribed for suppression of puberty

**AND**

**4** - The provider indicates a demonstrable knowledge what gonadotropins medically can and cannot do and their social benefits and risks

**AND**

**5** - One of the following:

**5.1** A documented real-life experience (living as the other gender) for at least three months prior to the administration of gonadotropin

**OR**

**5.2** A period of psychotherapy for at least three months by a mental health professional after the initial evaluation

**AND**

**6** - The patient meets all of the following to define gender dysphoria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex

- The disturbance is not concurrent with a physical intersex condition
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The transsexual identity has been present persistently for at least two years
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality

**AND**

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA

Diagnosis	Endometriosis
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Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - The patient has a diagnosis of Endometriosis

**AND**

2 - The patient has had an inadequate response, adverse reaction, or contraindication to an NSAID (non-steroidal anti-inflammatory drug)

**AND**

3 - The patient has had an inadequate response, adverse reaction, or contraindication to a hormonal contraceptive

**AND**

**4** - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

**AND**

**5** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA

Diagnosis Uterine leiomyomata (fibroids)

Approval Length 3 month(s)

Guideline Type Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of uterine leiomyomata (fibroids)

**AND**

**2** - The patient is symptomatic

**AND**

**3** - One of the following:

- Submission of medical records (e.g., chart notes) confirming the anticipated surgery date (or notation that surgery is planned once the fibroids shrink)
- Clinical rationale why surgical intervention is not required (Please document reasoning)

**AND**

**4** - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

**AND**

**5** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA

Diagnosis Prostate Cancer

Approval Length 12 month(s)

Guideline Type Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of prostate cancer

**AND**

**2** - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

**AND**

**3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
2/2/2026	Updated PDL Link

Gonadotropin Releasing Hormone Receptor (GnRH) Antagonist and Combinations



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-421254
<b>Guideline Name</b>	Gonadotropin Releasing Hormone Receptor (GnRH) Antagonist and Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Orilissa 200mg	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of moderate to severe pain associated with endometriosis</p> <p style="text-align: center;"><b>AND</b></p>	

**2 - ONE of the following:**

**2.1** History of inadequate pain control response following a minimum 3-month trial, or intolerance or contraindication, with ONE of the following:

- Danazol
- Combination (estrogen/progesterone) oral contraceptive
- Progestins

**OR**

**2.2** The patient had surgical ablation to prevent occurrence

**AND**

**3 - Treatment has not exceeded 6 months**

Product Name:Orilissa 150mg, Myfembree	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of moderate to severe pain associated with endometriosis</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <p><b>2.1</b> History of inadequate pain control response following a minimum 3-month trial, or intolerance or contraindication, with ONE of the following:</p> <ul style="list-style-type: none"> <li>• Danazol</li> <li>• Combination (estrogen/progesterone) oral contraceptive</li> </ul>	

- Progestins

**OR**

**2.2** The patient had surgical ablation to prevent occurrence

Product Name:Orilissa 150mg, Myfembree	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documented improvement in pain associated with endometriosis (improvement in dysmenorrhea and non-menstrual pelvic pain)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Treatment duration will not exceed a total of 24 months</p>	

Product Name:Oriahnn, Myfembree	
Diagnosis	Uterine leiomyomas (fibroids)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids)</p>	

**AND**

**2** - ONE of the following:

**2.1** History of inadequate pain control response following a minimum 3-month trial, or intolerance or contraindication, with ONE of the following:

- Danazol
- Combination (estrogen/progesterone) oral contraceptive
- Progestins

**OR**

**2.2** The patient had surgical ablation to prevent occurrence

Product Name: Oriahnn, Myfembree	
Diagnosis	Uterine leiomyomas (fibroids)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documented improvement in menstrual bleeding</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Treatment duration will not exceed a total of 24 months</p>	

**2 . Revision History**

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

10/14/2025	New program
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Growth Hormones



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512226
<b>Guideline Name</b>	Growth Hormones
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name: Genotropin, Genotropin Miniquick, Norditropin FlexPro, Nutropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton	
Diagnosis	Patients less than 18 years of age
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The request is for a patient with open epiphyses and with remaining growth potential</p>	

**AND**

**2** - The patient has had an evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for growth hormone therapy

**AND**

**3** - The patient has had an evaluation ruling out all other causes for short stature

**AND**

**4** - The patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids, or gonadotropic hormones

**AND**

**5** - One of the following:

**5.1** The patient has a diagnosis of Noonan Syndrome and both of the following:

- Patient's height is at least two standard deviations below the mean or below the fifth percentile for the patient's age and gender
- Bone age is less 16 years for male patients or less than 14 years for female patients

**OR**

**5.2** Patient has a diagnosis of Turner Syndrome and one of the following:

**5.2.1** Patient is female and has a bone age of less than 14 years

**OR**

**5.2.2** Patient is male and both of the following:

- Patient's height is at least two standard deviations below the mean or below the fifth percentile for the patient's age and gender

- Bone age is less than 16 years

**OR**

**5.3** Patient has a diagnosis of Prader-Willi Syndrome

**OR**

**5.4** The patient has a diagnosis of chronic renal insufficiency [less than 75 mL/min (milliliters/minute)], and their height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender

**OR**

**5.5** All of the following:

- The patient has a diagnosis of being small for gestational age
- The patient is two years of age or older
- The height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender

**OR**

**5.6** The patient is a newborn infant with evidence of hypoglycemia, and has low growth hormone level [less than 20 ng/mL (nanograms/milliliter)], low for age insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3

**OR**

**5.7** The patient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation) and all of the following:

**5.7.1** Height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender

**AND**

**5.7.2** Bone age is less than 16 years for male or less than 14 years for female

**AND**

**5.7.3** One of the following:

- The patient has failed two growth hormone stimulation tests (less than 10 ng/mL)
- The patient has failed one growth hormone stimulation test (less than 10 ng/mL) and one IGF-1 or IGFBP-3 test
- The patient has failed one growth hormone stimulation test (less than 10 ng/mL) or IGF-1 or IGFBP-3 test and they have deficiencies in three or more pituitary axes [e.g., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotrophic hormone (ACTH) or antidiuretic hormone (ADH)]

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Genotropin, Genotropin Miniquick, Norditropin FlexPro, Nutropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton	
Diagnosis	Patients greater than or equal to 18 years of age
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The request is for a patient with closed epiphyses and no remaining growth potential</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is being evaluated by an endocrinologist</p>	

**AND**

**3** - The patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids, or gonadotropic hormones

**AND**

**4** - The patient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation)

**AND**

**5** - One of the following:

**5.1** The patient has failed two growth hormone stimulation tests [less than 5 ng/mL (nanograms/mL)]

**OR**

**5.2** The patient has failed one growth hormone stimulation test (less than 5 ng/mL) and one insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3 test

**OR**

**5.3** The patient has failed one growth hormone stimulation test (less than 5 ng/mL) or IGFBP-3 test and has deficiencies in three or more pituitary axes [i.e., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotrophic hormone (ACTH) or antidiuretic hormone (ADH)] and has severe clinical manifestations of growth hormone deficiency as evident by alterations in body composition (e.g., decreased lean body mass, increased body fat), cardiovascular function (e.g., reduced cardiac output, lipid abnormalities) or bone mineral density

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Genotropin, Genotropin Miniquick, Norditropin FlexPro, Nutropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton

Diagnosis	All above indications
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Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Patient is less than 21 years of age, then all of the following:

**1.1** The request is for a patient with open epiphyses and with remaining growth potential

**AND**

**1.2** One of the following diagnoses:

- Chronic renal insufficiency
- Growth hormone deficiency
- Hypothalamic pituitary disease
- Newborn infant with evidence of hypoglycemia
- Noonan Syndrome
- Prader-Willi Syndrome
- Small for gestational age
- Turner Syndrome

**AND**

**1.3** The patient's growth rate on treatment is at least 2.5 cm/year (centimeters/year)

**AND**

**1.4** The patient does NOT have evidence of an expanding lesion or tumor formation

**AND**

**1.5** The patient has NOT undergone a renal transplant

**OR**

**2** - Patient is greater than or equal to 21 years of age, then all of the following:

**2.1** The request is for a patient with closed epiphyses and no remaining growth potential

**AND**

**2.2** The patient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease

**AND**

**2.3** There is documentation of improvement in clinical manifestations associated with growth hormone deficiency

Product Name: Serostim	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of Human Immune Deficiency Virus (HIV) with wasting or cachexia</p> <p><b>AND</b></p>	

**2** - The requested medication is indicated to increase lean body mass, body weight and physical endurance

**AND**

**3** - The patient is receiving and is compliant with antiretroviral therapy (ART)

**AND**

**4** - The patient has experienced an involuntary weight loss of greater than 10% pre-illness baseline or they have a body mass index of less than 20 kilograms (kg)/meter(m)<sup>2</sup>

**AND**

**5** - The patient has experienced an adverse event, allergy, or inadequate response to megestrol acetate, or the patient has a contraindication to treatment with megestrol acetate

**AND**

**6** - The patient has experienced an adverse event, allergy, or inadequate response to an anabolic steroid (e.g., testosterone, oxandrolone, nandrolone) or the patient has a contraindication to treatment with anabolic steroids

Product Name: Somavert	
Approval Length	12 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - The patient has a diagnosis of acromegaly	

**AND**

**2** - The patient is 18 years age or older

**AND**

**3** - One of the following:

**3.1** The patient has an inadequate response to one of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g. bromocriptine, cabergoline) therapy

**OR**

**3.2** The patient is not a candidate for all the following

- Surgery
- Radiation therapy
- Dopamine agonist (e.g. bromocriptine, cabergoline) therapy

**AND**

**4** - The patient has tried and failed, or has a contraindication or intolerance to, generic octreotide (a somatostatin analogue)

**AND**

**5** - The requested medication is prescribed by, or in consultation with, an endocrinologist

Product Name: Somavert	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a documented positive clinical response to the requested therapy (e.g., biochemical control; decrease or normalization of IGF-1 levels)

Product Name: Skytrofa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient is one year or age or older

**AND**

2 - Patient's weight is greater than 11.5 kg (kilograms)

**AND**

3 - Patient has growth failure secondary to growth hormone deficiency (GHD)

**AND**

4 - Patient has short stature as defined by height that is greater than or equal to 2 standard deviations below the mean for chronological age and one of the following:

4.1 Patient has hypothalamic-pituitary defects (e.g., major congenital malformation, tumor, or irradiation) and a deficiency of greater than or equal to 1 additional pituitary hormone

**OR**

**4.2** Patient had an inadequate response to growth hormone (GH) provocation tests on two separate stimulation tests as defined as a serum peak GH concentration less than 10 ng/mL (nanograms per milliliter)

**AND**

**5** - Other causes of growth failure must be ruled out (e.g., malnutrition, hypothyroidism, hypercortisolism)

Product Name: Skytrofa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has shown a beneficial response compared to pre-treatment baseline [with lonapegsomatropin-tcgd or somatropin (if used as switch maintenance)] as evidenced by one of the following:</p> <ul style="list-style-type: none"> <li>• Improvement in height</li> <li>• Improvement in growth velocity</li> </ul>	

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

H1 Blockers - Non-Sedating



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512227
<b>Guideline Name</b>	H1 Blockers - Non-Sedating
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name: Brand Allegra OTC, generic fexofenadine Rx/OTC, fexofenadine D OTC, cetirizine D OTC, cetirizine oral soln 5mg/5mL OTC, Brand Clarinex, generic desloratadine, Clarinex-D, Claritin, Claritin D, Xyzal	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has had a two-week trial of ONE preferred medication*</p>	
Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Harliku



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-501246
<b>Guideline Name</b>	Harliku
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Harliku	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a diagnosis of alkaptonuria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following:</p> <ul style="list-style-type: none"> <li>• Urinary homogentisic acid (HGA) excretion greater than 0.4g per 24 hours</li> <li>• Biallelic mutation in homogentisate 1,2-dioxygenase (HGD) gene confirmed by genetic testing</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Harliku will not be used in combination with any of the following:</p> <ul style="list-style-type: none"> <li>• Generic nitisinone</li> <li>• Nityr</li> <li>• Orfadin</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Prescribed by or in consultation with a geneticist, metabolic disease specialist, or rheumatologist</p>	

Product Name: Harliku	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Harliku therapy (e.g., reduced urinary HGA levels, improvement in joint symptoms)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Harliku will not be used in combination with any of the following:</p> <ul style="list-style-type: none"> <li>• Generic nitisinone</li> <li>• Nityr</li> <li>• Orfadin</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by or in consultation with a geneticist, metabolic disease specialist, or rheumatologist</p>	

## 2 . Revision History

Date	Notes
1/16/2026	New

HCG



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-509215
<b>Guideline Name</b>	HCG
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

### Guideline Note:

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Prepubertal Cryptorchidism
Approval Length	6 Week(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction

**2 . Revision History**

Date	Notes
1/26/2026	Combined formularies. Removed GPI for Novarel 10000 Unit (obsolete). No changes to clinical criteria.

Hematopoietic, Hematinic Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512228
<b>Guideline Name</b>	Hematopoietic, Hematinic Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name:Epogen, Procrit, Retacrit	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has been evaluated for adequate iron stores</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)

**AND**

**3** - Patient will achieve and maintain hemoglobin levels in ONE of the following conditions:

- Treatment of anemia secondary to myelosuppressive anticancer chemotherapy: Hb levels should not exceed 10 g/dL
- Treatment of anemia related to zidovudine therapy in HIV-infected patients: Hb levels should not exceed 12 g/dL
- Treatment of anemia secondary to CKD (Dialysis patient): Hb levels should not exceed 11 g/dL
- Treatment of anemia secondary to CKD (Non-Dialysis patient): 10 g/dL for adults; 12 g/dL for pediatrics
- To reduce the need for allogenic transfusions in surgery recipients when a significant blood loss is anticipated and ESA being prescribed to achieve and maintain hemoglobin levels within the range of 10 to 13 g/dL
- Treatment of anemia secondary to myelodysplastic syndrome (MDS) : Hb levels should not exceed 12 g/dL
- Treatment of anemia secondary to myeloproliferative neoplasms (MPN): Hb levels should not exceed 10 g/dL

**AND**

**4** - NOT used for the following:

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

**AND**

**5** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:Aranesp	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has been evaluated for adequate iron stores</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient will achieve and maintain hemoglobin levels in ONE of the following conditions:</p> <ul style="list-style-type: none"> <li>• Treatment of anemia secondary to myelosuppressive anticancer chemotherapy: Hb levels should not exceed 10 g/dL</li> <li>• Treatment of anemia secondary to CKD (Dialysis patient): Hb levels should not exceed 11 g/dL</li> <li>• Treatment of anemia secondary to CKD (Non-Dialysis patient): 10 g/dL for adults; 12 g/dL for pediatrics</li> <li>• Treatment of anemia secondary to myelodysplastic syndrome (MDS) : Hb levels should not exceed 12 g/dL</li> <li>• Treatment of anemia secondary to myeloproliferative neoplasms (MPN): Hb levels should not exceed 10 g/dL</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>4 - NOT used for the following:</p> <ul style="list-style-type: none"> <li>• Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis</li> <li>• Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers</li> </ul>	

- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

**AND**

**5** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Mircera	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has been evaluated for adequate iron stores</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient will achieve and maintain hemoglobin levels in ONE of the following conditions:</p> <ul style="list-style-type: none"> <li>• Treatment of anemia secondary to CKD (Dialysis patient): Hb levels should not exceed 11 g/dL</li> <li>• Treatment of anemia secondary to CKD (Non-Dialysis patient): 10 g/dL for adults; 12 g/dL for pediatrics</li> </ul>	

**AND**

**4** - NOT used for the following:

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

**AND**

**5** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes

\*PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Vafseo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has been evaluated for adequate iron stores</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)</p> <p style="text-align: center;"><b>AND</b></p>	

**3 - BOTH of the following:**

- Used for the treatment of anemia secondary to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least three months
- Patient will achieve and maintain hemoglobin level of 11 g/dL or less

**AND**

**4 - NOT used for the following:**

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

**AND**

**5 - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met**

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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**2 . Revision History**

Date	Notes
2/2/2026	Updated PDL Link

Hemgenix



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422564
<b>Guideline Name</b>	Hemgenix
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Hemgenix	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is at least 18 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by or in consultation with a hematologist</p>	

**AND**

**3** - The patient has a diagnosis of moderately severe or severe congenital factor IX deficiency (e.g., pre-treatment factor IX less than or equal to 2%), as confirmed by blood coagulation testing

**AND**

**4** - The patient has ONE or more of the following:

- Currently uses factor IX prophylaxis therapy
- Current or historical life-threatening hemorrhage

**AND**

**5** - Repeated, serious spontaneous bleeding episodes

**AND**

**6** - The patient has been recently tested (within two weeks prior to administration of Hemgenix) and found negative for factor IX inhibitors

**AND**

**7** - The patient does not have active hepatitis B and/or hepatitis C infection

**AND**

**8** - The patient does not have uncontrolled HIV infection

**AND**

**9** - Liver health assessments including enzyme testing [ALT, AST, ALP and total bilirubin] and

hepatic ultrasound and elastography have been performed to rule out radiological liver abnormalities and/or sustained liver enzyme elevations

**AND**

**10** - The patient has not received previous gene therapy for Hemophilia B\*

**AND**

**11** - Prescriber attestation that factor IX activity will be monitored periodically per package insert (e.g., weekly for three months) post-administration

Notes	*Limited to one treatment per lifetime
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## 2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Hereditary Angioedema Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-398222
<b>Guideline Name</b>	Hereditary Angioedema Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Cinryze	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of HAE (hereditary angioedema)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

**AND**

**3** - ONE of the following:

**3.1** The medication is being used as prophylaxis against attacks

**OR**

**3.2** BOTH of the following:

- The medication is being used for the treatment of acute HAE attacks
- The medication is NOT used in combination with other approved treatment for acute HAE attacks

**AND**

**4** - Prescribed by or in consultation with an allergist or immunologist

Product Name:Haegarda, Orladeyo, Takhzyro	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of HAE (hereditary angioedema)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

**AND**

**3** - The requested medication is being used as prophylaxis against attacks

**AND**

**4** - Prescribed by or in consultation with an allergist or immunologist

Product Name: Brand Firazyr, generic icatibant, Brand Sajazir, Ruconest	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of HAE (hereditary angioedema)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:</p> <ul style="list-style-type: none"> <li>• C1-INh antigenic level below the lower limit of normal</li> <li>• C1-INh functional level below the lower limit of normal</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The requested medication is being used for the treatment of acute HAE attacks</p>	

**AND**

**4** - The requested medication is NOT used in combination with other approved treatment for acute HAE attacks

**AND**

**5** - Prescribed by or in consultation with an allergist or immunologist

Product Name:Kalbitor	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of HAE (hereditary angioedema)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is at least 12 years old</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:</p> <ul style="list-style-type: none"> <li>• C1-INh antigenic level below the lower limit of normal</li> <li>• C1-INh functional level below the lower limit of normal</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The requested medication is being used for the treatment of acute HAE attacks</p>	

**AND**

**5** - The requested medication is NOT used in combination with other approved treatment for acute HAE attacks

**AND**

**6** - Prescribed by or in consultation with an allergist or immunologist

Product Name: Berinert	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of HAE (hereditary angioedema)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:</p> <ul style="list-style-type: none"> <li>• C1-INh antigenic level below the lower limit of normal</li> <li>• C1-INh functional level below the lower limit of normal</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The requested medication is being used for the treatment of acute HAE attacks</p> <p style="text-align: center;"><b>AND</b></p>	

**4** - The requested medication is NOT used in combination with other approved treatment for acute HAE attacks

**AND**

**5** - Prescribed by or in consultation with an allergist or immunologist

**AND**

**6** - ONE of the following:

- History of trial and failure, contraindication, or intolerance to Ruconest
- The patient is 12 years of age or younger and there is documentation that the patient has history of laryngeal attacks

## 2 . Revision History

Date	Notes
9/17/2025	New program

Hetlioz



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-397265
<b>Guideline Name</b>	Hetlioz
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Hetlioz capsules, generic tasimelteon capsules	
Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of Non-24 disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernycthemeral syndrome)</p>	

**AND**

**2** - The medication is being prescribed by or in consultation with a sleep specialist

**AND**

**3** - The patient had an adverse reaction, contraindication, or an inadequate response (after at least three months of therapy) to a therapeutic dose of melatonin

Product Name: Brand Hetlioz capsules, generic tasimelteon capsules	
Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy</p>	

Product Name: Brand Hetlioz capsules, generic tasimelteon capsules, Hetlioz LQ	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of Smith-Magenis Syndrome (SMS)</p>	

**AND**

**2** - One of the following:

- For Hetlioz (tasimelteon) capsules, the patient is at least 16 years of age
- For Hetlioz LQ, the patient is 3 through 15 years of age

**AND**

**3** - The patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking)

**AND**

**4** - Prescribed by a neurologist or a specialist in sleep disorder

**AND**

**5** - The patient had an adverse reaction, contraindication, or an inadequate response (after at least three months of therapy) to a therapeutic dose of melatonin

Product Name: Brand Hetlioz capsules, generic tasimelteon capsules, Hetlioz LQ	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality)</p>	

## 2 . Revision History

Date	Notes
9/18/2025	New guideline

Hormones and Hormone Modifiers



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512229
<b>Guideline Name</b>	Hormones and Hormone Modifiers
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name:Brand Androgel, Natesto, Brand Testim, Brand Vogelxo, generic testosterone TD gel, testosterone soln	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is male</p>	

**AND**

**2** - The requested medication is being used for Primary (congenital or acquired) or Secondary (congenital or acquired) hypogonadism

**AND**

**3** - Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used

**AND**

**4** - Patient does NOT have any one of the following:

- Breast or prostate cancer
- A palpable prostate nodule or induration
- Prostate-specific antigen greater than 4 ng/ml (nanograms/milliliter)
- Severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) greater than 19

**AND**

**5** - Patient does not have a hematocrit greater than 50%

**AND**

**6** - Patient does NOT have untreated severe obstructive sleep apnea

**AND**

**7** - Patient does NOT have uncontrolled or poorly controlled heart failure

**AND**

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<b>8</b> - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Brand Androgel, Natesto, Brand Testim, Brand Vogelxo, generic testosterone TD gel, testosterone soln	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is using the hormones to change their physical characteristics</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is a female-to-male transsexual</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Xyosted	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p>	

**1** - Diagnosis of Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 E29.1)

**AND**

**2** - Patient is male at birth

**AND**

**3** - One of the following:

**3.1** Two pre-treatment serum total testosterone levels less than 300 ng/dL (nanograms/deciliter) [less than 10.4 nanomole (nmol)/L (liter)] or less than the reference range for the lab

**OR**

**3.2** Both of the following:

- Patient has a condition that may cause altered sex hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV, liver disorder, diabetes, obesity)
- One pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (less than 0.17 nmol/L) or less than the reference range for the lab

**OR**

**3.3** Patient has a history of one of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

**AND**

**4** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

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Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Xyosted	
Diagnosis	Gender Dysphoria
Approval Length	If the patient is new to testosterone therapy, approval length is 6 months; Otherwise, approval length in 12 months
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is using the hormones to change their physical characteristics</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is a female-to-male transsexual</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than 18 years of age</p>	

**AND**

**2** - Patient is male

**AND**

**3** - Patient has a diagnosis of primary hypogonadism or hypogonadotropic hypogonadism (congenital or acquired)

**AND**

**4** - Patient has history of failure, contraindication, or intolerance to both testosterone cypionate and testosterone enanthate injection

**AND**

**5** - Patient has signs/symptoms consistent with hypogonadism (e.g., low libido, decreased morning erections, loss of body hair, low bone mineral density, gynecomastia, small testes)

**AND**

**6** - Patient does NOT have “age-related hypogonadism” or another hypogonadal condition not associated with structural or genetic etiologies

**AND**

**7** - Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used

**AND**

**8** - Patient is only receiving one androgen or anabolic agent

**AND**

**9** - Patient does NOT have current or history of breast cancer

**AND**

**10** - Patient does not have a HCT (hematocrit) greater than 50%

**AND**

**11** - Patient does NOT have uncontrolled hypertension or heart failure

**AND**

**12** - Patient does NOT have uncontrolled obstructive sleep apnea

**AND**

**13** - Medication is prescribed by, or in consultation with, an endocrinologist or urologist

Product Name:Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
<b>1</b> - The patient is greater than 18 years of age	

**AND**

**2** - Patient is male

**AND**

**3** - Patient has a diagnosis of primary hypogonadism or hypogonadotropic hypogonadism (congenital or acquired)

**AND**

**4** - Patient has history of failure, contraindication, or intolerance to both testosterone cypionate and testosterone enanthate injection

**AND**

**5** - Patient has signs/symptoms consistent with hypogonadism (e.g., low libido, decreased morning erections, loss of body hair, low bone mineral density, gynecomastia, small testes)

**AND**

**6** - Patient does NOT have “age-related hypogonadism” or another hypogonadal condition not associated with structural or genetic etiologies

**AND**

**7** - Patient is only receiving one androgen or anabolic agent

**AND**

**8** - Patient does NOT have current or history of breast cancer

**AND**

**9** - Patient does not have a HCT (hematocrit) greater than 50%

**AND**

**10** - Patient does NOT have uncontrolled hypertension or heart failure

**AND**

**11** - Patient does NOT have uncontrolled obstructive sleep apnea

**AND**

**12** - Medication is prescribed by, or in consultation with, an endocrinologist or urologist

**AND**

**13** - Patient has disease improvement and/or stabilization

Product Name:Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
<b>1</b> - Patient is using the hormones to change their physical characteristics	

<b>AND</b>	
2 - Patient is a female-to-male transsexual	
<b>AND</b>	
3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has disease improvement and/or stabilization</p>	

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Ileal Bile Acid Transporter (IBAT) Inhibitor (D7F)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422514
<b>Guideline Name</b>	Ileal Bile Acid Transporter (IBAT) Inhibitor (D7F)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Bylvay	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is three months of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is diagnosed with progressive familial intrahepatic cholestasis (PFIC) type 1 or type 2, confirmed by a genetic test

**AND**

**3** - Patient has elevated serum bile acid concentration

**AND**

**4** - Patient experiences persistent moderate to severe pruritus

**AND**

**5** - Patient does NOT have any of the following:

- Positive test for the ABCB11 gene variant that predicts complete absence of the bile salt export pump (BSEP) protein
- Prior hepatic decompensation event
- Another concomitant liver disease
- An international normalized ratio (INR) greater than 1.4
- Significant portal hypertension
- An alanine aminotransferase (ALT) or total bilirubin (TB) level more than 10 times the upper limit of normal (ULN)
- Medical history or ongoing chronic diarrhea
- Decompensated cirrhosis

**AND**

**6** - The requested medication is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist)

Product Name:Bylvay	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Patient is three months of age or older

**AND**

**2** - Patient is diagnosed with progressive familial intrahepatic cholestasis (PFIC) type 1 or type 2, confirmed by a genetic test

**AND**

**3** - Patient experiences persistent moderate to severe pruritus

**AND**

**4** - Patient does NOT have any of the following:

- Positive test for the ABCB11 gene variant that predicts complete absence of the bile salt export pump (BSEP) protein
- Prior hepatic decompensation event
- Another concomitant liver disease
- An international normalized ratio (INR) greater than 1.4
- Significant portal hypertension
- An alanine aminotransferase (ALT) or total bilirubin (TB) level more than 10 times the upper limit of normal (ULN)
- Medical history or ongoing chronic diarrhea
- Decompensated cirrhosis

**AND**

**5** - The requested medication is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist)

**AND**

**6** - Patient has experienced a reduction in serum bile acids from baseline

**AND**

**7** - Patient has experienced improvement in pruritus from baseline

**AND**

**8** - Patient has not experienced any treatment-restricting adverse effects (e.g., persistent diarrhea; persistent fat-soluble vitamin deficiency despite Vitamin A, D, E, K supplementation; elevated liver function tests [alanine aminotransferase (ALT), total bilirubin (TB), direct bilirubin (DB)])

Product Name:Livmarli	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient is 1 year of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is diagnosed with Alagille syndrome</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient experiences persistent moderate to severe pruritus</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Patient does NOT have any of the following:</p>	

- Chronic diarrhea requiring ongoing IV (intravenous) fluid or nutritional intervention
- Prior hepatic decompensation event
- Significant portal hypertension
- Decompensated cirrhosis
- Another concomitant liver disease

**AND**

**5** - The requested medication is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist)

**AND**

**6** - Patient has failed an adequate trial, or is intolerant to, or has a contraindication to at least one pruritus treatment (e.g., ursodeoxycholic acid [ursodiol], cholestyramine, rifampin, naloxone, naltrexone, antihistamine)

Product Name: Livmarli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has experienced a reduction in serum bile acids from baseline</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient has experienced improvement in pruritus from baseline</p>	

**AND**

**4** - Patient has not experienced any treatment-restricting adverse effects (e.g., persistent diarrhea; persistent fat-soluble vitamin deficiency despite Vitamin A, D, E, K supplementation; elevated liver function tests [alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin (TB), direct bilirubin (DB)])

## **2 . Revision History**

Date	Notes
10/21/2025	New guideline

Immunomodulator Drugs



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512230
<b>Guideline Name</b>	Immunomodulator Drugs
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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**1 . Criteria**

Product Name: Actemra, Tofidence, Tylene, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orenzia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1** - The patient has a diagnosis of moderately to severely active Rheumatoid Arthritis (RA)

**AND**

**2** - The patient has had a rheumatology consultation (please document date of consultation)

**AND**

**3** - One of the following:

**3.1** Patient has had RA for less than 6 months (early RA) and both of the following:

- Patient has high disease activity
- Patient has had an inadequate or adverse reaction to a disease modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline, or sulfasalazine)

**OR**

**3.2** Patient has had RA for 6 months or longer (intermediate or long-term disease duration) and one of the following:

**3.2.1** Patient has high disease activity

**OR**

**3.2.2** Patient has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline, or sulfasalazine)

**AND**

**4** - Patient has a negative tuberculin test

**AND**

**5** - The patient does not have an active infection or a history of recurring infections

**AND**

**6** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**7** - One of the following:

**7.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**7.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**8** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**9** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**9.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**9.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**10** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of moderate or severe psoriatic arthritis

**AND**

**2** - The patient has had a rheumatology or dermatology consultation (please document date of consultation)

**AND**

**3** - The patient has had an inadequate response or a contraindication to treatment with one of the following:

**3.1** One nonsteroidal anti-inflammatory drug (NSAID)

**OR**

**3.2** One of the following DMARDs (disease modifying antirheumatic drugs):

- Methotrexate
- Leflunomide
- Cyclosporine
- Sulfasalazine

**AND**

**4** - Patient has a negative tuberculin test

**AND**

**5** - The patient does not have an active infection or a history of recurring infections

**AND**

**6** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**7** - One of the following:

**7.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**7.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**8** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**9** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**9.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**9.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**10** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Oencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of ankylosing spondylitis

**AND**

**2** - The patient has had an inadequate response to NSAIDs (nonsteroidal anti-inflammatory drugs)

**AND**

**3** - Patient has a negative tuberculin test

**AND**

**4** - The patient does not have an active infection or a history of recurring infections

**AND**

**5** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**6** - One of the following:

**6.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**6.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**7** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**8** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**8.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**8.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**9** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Oencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Juvenile RA/Juvenile Idiopathic Arthritis
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Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - The patient has a diagnosis of moderately or severely active juvenile RA (rheumatoid arthritis) or juvenile idiopathic arthritis

**AND**

**2** - The patient has at least five swollen joints

**AND**

**3** - The patient has three or more joints with limitation of motion and pain and/or tenderness

**AND**

**4** - The patient has had inadequate response to one DMARD (disease modifying antirheumatic drug)

**AND**

**5** - Patient has a negative tuberculin test

**AND**

**6** - The patient does not have an active infection or a history of recurring infections

**AND**

**7** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**8** - One of the following:

**8.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**8.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**9** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**10** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**10.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**10.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**11** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of chronic, moderate to severe plaque psoriasis

**AND**

2 - The requested medication is prescribed by a dermatologist

**AND**

3 - The patient has failed to adequately respond to a topical agent

**AND**

4 - The patient has failed to adequately respond to at least one oral treatment

**AND**

5 - Patient has a negative tuberculin test

**AND**

6 - The patient does not have an active infection or a history of recurring infections

**AND**

7 - The patient is not using more than one biologic at a time (combination therapy)

**AND**

8 - One of the following:

**8.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**8.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**9** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**10** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**10.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**10.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**11** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orenzia, Otezla,

Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of moderate to severe Crohn's Disease</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p>2.1 The patient has failed to adequately respond to conventional therapy (e.g., sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide)</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 The patient has fistulizing Crohn's Disease</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient has a negative tuberculin test</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - The patient does not have an active infection or a history of recurring infections</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - The patient is not using more than one biologic at a time (combination therapy)</p>	

**AND**

**6** - One of the following:

**6.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**6.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**7** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**8** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**8.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**8.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**9** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Oencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of moderate to severe ulcerative colitis

**AND**

2 - The patient has failed to adequately respond to at least one of the following standard therapies:

- Corticosteroids
- 5-aminosalicylic acid agents
- Immunosuppressants
- Thiopurines

**AND**

3 - Patient has a negative tuberculin test

**AND**

4 - The patient does not have an active infection or a history of recurring infections

**AND**

**5** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**6** - One of the following:

**6.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**6.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**7** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**8** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**8.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**8.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**9** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of one of the following:

- Familial Cold Autoinflammatory Syndromes (FCAS)
- Muckle-Wells Syndrome (MWS)
- Neonatal-Onset Multisystem Inflammatory Disease (NOMID)

**AND**

2 - Patient has a negative tuberculin test

**AND**

3 - The patient does not have an active infection or a history of recurring infections

**AND**

4 - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**5** - One of the following:

**5.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**5.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**6** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**7** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**7.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**7.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**8** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola,

Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orenzia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Refractory Atopic Dermatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of refractory, moderate to severe atopic dermatitis (AD)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient has documented trial and failure to at least one other systemic option for AD</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - If the request is for Rinvoq, the patient weighs at least 40 kg (kilograms)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - The requested medication is prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Dermatologist</li> <li>• Allergist</li> <li>• Immunologist</li> <li>• Otolaryngologist</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>5 - Patient has a negative tuberculin test</p>	

**AND**

**6** - The patient does not have an active infection or a history of recurring infections

**AND**

**7** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**8** - One of the following:

**8.1** The requested medication is being prescribed for an FDA-approved indication and patient is appropriate age per FDA labeling

**OR**

**8.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**9** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**10** - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

**10.1** The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

**AND**

**10.2** Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

**AND**

**11** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name:Spevigo

Approval Length

14 Day(s)

Guideline Type

Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of generalized pustular psoriasis (GPP)

**AND**

**2** - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Immunologist
- Rheumatologist

**AND**

**3** - The patient does not have any of the following conditions: synovitis, acne, pustulosis, hyperostosis, osteitis (SAPHO) syndrome, erythrodermic plaque psoriasis without pustules or with pustules restricted to psoriatic plaques, or drug-triggered acute generalized exanthematous pustulosis (AGEP)

**AND**

**4** - The patient is experiencing an acute GPP flare of moderate to severe intensity defined by all the following:

- GPP Global Assessment (GPPGA) total score of greater than or equal to 3 (moderate)
- Presence of fresh pustules (new or worsening)
- A GPPGA pustulation sub score of at least 2 (mild)
- At least 5% of body surface area with erythema and the presence of pustules

**AND**

**5** - Patient has a negative tuberculin test

**AND**

**6** - The patient does not have an active infection or a history of recurring infections

**AND**

**7** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**8** - One of the following:

**8.1** The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

**OR**

**8.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**9** - The patient has not received live or live-attenuated vaccines within the past four weeks

and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**10** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:Uplizna	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has been diagnosed with neuromyelitis optica spectrum disorder (NMOSD)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has positive serologic test for anti-AQP4 antibodies</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient has a history of at least 1 relapse that required rescue therapy within the year prior to treatment or at least 2 relapses that required rescue therapy in two years prior to treatment</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Patient has an Expanded Disability Status Score (EDSS) of less than or equal to 8.0</p> <p style="text-align: center;"><b>AND</b></p>	

**5** - Prescribed by, or in consultation with, a neurologist

**AND**

**6** - Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment and confirmed negative for active HBV

**AND**

**7** - Prescriber attestation that serum immunoglobulin will be monitored at beginning, during, and after discontinuation of treatment until B-cell repletion

**AND**

**8** - Patient has a negative tuberculin test

**AND**

**9** - The patient does not have an active infection or a history of recurring infections

**AND**

**10** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**11** - One of the following:

**11.1** The requested medication is being prescribed for an FDA-approved indication and patient is appropriate age per FDA labeling

**OR**

**11.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**12** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**13** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:Uplizna

Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - The patient has been diagnosed with neuromyelitis optica spectrum disorder (NMOSD)

**AND**

**2** - Patient has positive serologic test for anti-AQP4 antibodies

**AND**

**3** - Prescribed by, or in consultation with, a neurologist

**AND**

**4** - Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment and confirmed negative for active HBV

**AND**

**5** - Prescriber attestation that serum immunoglobulin will be monitored at beginning, during, and after discontinuation of treatment until B-cell repletion

**AND**

**6** - Patient has a negative tuberculin test

**AND**

**7** - The patient does not have an active infection or a history of recurring infections

**AND**

**8** - The patient is not using more than one biologic at a time (combination therapy)

**AND**

**9** - One of the following:

**9.1** The requested medication is being prescribed for an FDA-approved indication and patient is appropriate age per FDA labeling

**OR**

**9.2** The prescriber has provided clinical justification for off-label usage (please document clinical justification)

**AND**

**10** - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

**AND**

**11** - Documentation of positive disease response as indicated by stabilization/improvement one of the following:

- Neurologic symptoms as evidence by a decreased in acute relapses
- Stability or improvement in Expanded Disability Status Score (EDSS)
- Reduced hospitalizations
- Reduction in plasma exchange treatments

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Increlex



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-458264
<b>Guideline Name</b>	Increlex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Increlex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Submission of medical records documenting all of the following:</p> <p>1.1 Diagnosis of severe primary IGF-1 deficiency (PIGFD)</p>	

**AND**

**1.2** Documentation of height below -3.0 SD (standard deviation) mean for age and gender

**AND**

**1.3** Documentation of IGF-1 below -3.0 SD mean for age and gender

**AND**

**1.4** Documentation of both of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Calculated growth velocity

**AND**

**1.5** One of the following:

**1.5.1** Patient is unresponsive to a trial of growth hormone therapy

**OR**

**1.5.2** Documentation of one of the following:

- Very low or undetectable level of GHBP
- Very low or undetectable level of GHR mutations known to cause Laron syndrome/GH insensitivity syndrome
- GH1 gene deletion (GHD type 1A)
- GH-neutralizing antibodies
- STT5b gene mutation
- IGF-1 gene deletion or mutation

**AND**

**2** - Other causes of low IGF-I levels have been ruled out (e.g., growth hormone deficiency, undernutrition, hepatic disease)

**AND**

**3** - Patient will not be treated with concurrent growth hormone therapy

**AND**

**4** - Prescribed by an endocrinologist

Product Name: Increlex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Submission of medical records documenting a height increase of at least 2 centimeters/year over the previous year of treatment as confirmed by all of the following:

- Previous length/height and date obtained
- Current length/height and date obtained
- Calculated growth velocity
- Growth chart for height for age and gender

**AND**

**2** - Submission of medical records documenting both of the following:

- Expected adult height not obtained
- Expected adult height goal

**AND**

**3** - Patient is not treated with concurrent growth hormone therapy

**AND**

**4** - Prescribed by an endocrinologist

## 2 . Revision History

Date	Notes
12/3/2025	New guideline

Incretin Mimetics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512231
<b>Guideline Name</b>	Incretin Mimetics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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### 1 . Criteria

Product Name:Trulicity, Exenatide, liraglutide (generic Victoza), Brand Victoza, Rybelsus, Ozempic, Mounjaro, Xultophy, Soliqua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Used for ONE of the following:</p> <ul style="list-style-type: none"> <li>Adjunct to diet and exercise to improve glycemic control in patients with type 2 diabetes mellitus (T2DM)</li> </ul>	

- Reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in recipients with type 2 diabetes and established cardiovascular disease

**AND**

**2** - Documentation of A1C lab result within past 180 days

**AND**

**3** - Patient does NOT have any of the following:

- History of pancreatitis
- Type 1 diabetes mellitus (T1DM)

**AND**

**4** - Medication is not being prescribed for weight loss in absence of T2DM indication

**AND**

**5** - Medication prescribed at FDA-approved dose for T2DM indication

**AND**

**6** - Patient is appropriate age per FDA label

**AND**

**7** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

\*PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Trulicity, Exenatide, liraglutide (generic Victoza), Brand Victoza, Rybelsus, Ozempic, Mounjaro, Xultophy, Soliqua

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation of positive response from therapy</p>	

Product Name:Wegovy	
Diagnosis	Risk reduction of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Medication is being prescribed for risk reduction of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is at least 18 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Documentation that patient has a body mass index (BMI) at least 27 kg/m<sup>2</sup></p>	

**AND**

**4** - Established cardiovascular (CV) disease as evidenced by at least ONE of the following criteria:

- Prior myocardial infarction
- Prior ischemic or hemorrhagic stroke
- Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) < 0.85 (at rest), or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease
- Patient has established CV disease verified by specialist and the specialist has provided documentation to confirm medication is being prescribed to reduce the patient's specific CV risk (submission of documentation required)

**AND**

**5** - Prescribed by, or in consultation with, a cardiologist or vascular specialist

**AND**

**6** - ONE of the following:

- Patient does NOT have type 1 or type 2 diabetes
- Patient does have type 1 or type 2 diabetes and is receiving appropriate diabetic care with an alternative medication therapy

**AND**

**7** - Patient does NOT have any contraindications for use of Wegovy

**AND**

**8** - Medication will not be used in combination with another glucagon-like peptide (GLP-1) therapy

**AND**

**9** - Documentation that patient has received individualized healthy lifestyle counseling

**AND**

**10** - Provider attestation that in addition to Wegovy, the provider will maintain standard of care treatment for the patient's established CV disease

Product Name:Wegovy	
Diagnosis	Risk reduction of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Dose has been titrated to 2.4 mg once weekly</li> <li>• There is a reason why the 2.4 mg once weekly maintenance dose is not appropriate (prescriber must document reasoning)</li> </ul>	

Product Name:Wegovy	
Diagnosis	Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a diagnosis of Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with fibrosis stage 2 or 3 confirmed by submission of medical records of at least one of the following:</p>	

- Liver biopsy
- Vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
- Magnetic resonance elastography (MRE)

**AND**

**2** - Patient is at least 18 years of age

**AND**

**3** - Patient does not have any contraindications for use of the requested medication (e.g. personal or family history of MTC, MEN 2, or hypersensitivity)

**AND**

**4** - Medication will not be used in combination with another glucagon-like peptide (GLP-1) therapy

**AND**

**5** - Prescriber attestation that the requested medication is being prescribed in conjunction with diet and exercise

Product Name: Wegovy	
Diagnosis	Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
<b>1</b> - Documentation of positive clinical response to therapy	

**AND**

**2** - One of the following:

- Patient is being prescribed the FDA-(Food and Drug Administration) recommended maintenance dose of 2.4mg weekly
- Dose was decreased to 1.7mg weekly due to intolerance

Product Name:Zepbound	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is at least 18 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Submission of medical records documenting Medication is being prescribed for moderate to severe obstructive sleep apnea (OSA) in adults with obesity, with OSA defined by one of the following:</p> <p><b>2.1</b> The patient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study from a certified or accredited sleep disorder facility</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> Both of the following:</p> <ul style="list-style-type: none"> <li>• Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study from a certified or accredited sleep disorder facility</li> </ul>	

- One of the following signs/symptoms are present: Daytime sleepiness; Nonrestorative sleep; Fatigue; Insomnia; Waking up with breath holding, gasping, or choking; Habitual snoring noted by a bed partner or other observer; Observed apnea

**OR**

**2.3** Both of the following:

- The patient is not an appropriate candidate for a facility sleep study due to immobility, safety, or critical illness
- Zepbound is being prescribed by, or in consultation with, a board-certified sleep specialist or pulmonologist for a diagnosis of moderate to severe OSA

**AND**

**3** - The patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP), unless there is rationale from provider as to why treatment is not indicated

**AND**

**4** - Documentation that the patient has a body mass index (BMI) > 30 kg/m<sup>2</sup>

**AND**

**5** - ONE of the following:

- Patient does NOT have type 1 or type 2 diabetes
- Patient does have type 1 or type 2 diabetes and is receiving appropriate diabetic care with an alternative medication therapy

**AND**

**6** - The patient does not have any contraindications for use of Zepbound

**AND**

7 - Provider attests that this medication will be used in combination with a reduced calorie diet and increased physical activity

Product Name:Zepbound	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP), unless there is rationale from provider as to why treatment is not indicated</p>	

## 2 . Revision History

Date	Notes
2/2/2026	Updated PDL Link

Insulin Pen Needles and Syringes



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512232
<b>Guideline Name</b>	Insulin Pen Needles and Syringes
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State Kansas (ACUKS, ACUKSC, ACUKSEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/2/2026
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**1 . Criteria**

Product Name:Non-preferred insulin pen needles and insulin syringes	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - If the request is non-preferred*, history of failure to a preferred* Embecta insulin pen needle or syringe as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - If the request is non-preferred*, physician has provided documentation as to why the patient is unable to use a preferred* Embecta product (document rationale)</p>	
Notes	*PDL links are listed in Background.

Product Name:All insulin pen needles and insulin syringes	
Diagnosis	Requests exceeding 6 pen needles or syringes per day*
Approval Length	12 month(s)
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - Physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin</p>	
Notes	*The quantity limit for both pen needles and syringes is 6 of each per day.

## 2 . Background

**Benefit/Coverage/Program Information**

**PDL links**

**CO:** <https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html>

**HI:** <https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html>

**MD:** <https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html>

**NJ:** <https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html>

**NY/NY EPP:** <https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html>

**PA:** <https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP>

**RI:** <https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html>

**AZ:** <https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP>

**KS:** <https://www.uhcprovider.com/en/health-plans-by-state/kansas-health-plans/ks-comm-plan-home/ks-cp-pharmacy.html>

**NM:** <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

**VA:** <https://www.uhcprovider.com/en/health-plans-by-state/virginia-health-plans/va-comm-plan-home/va-cp-pharmacy.html>

**WA:** <https://www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home/wa-cp-pharmacy.html>

**NE:** <https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-pharmacy.html>

**IN:** <https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm->

plan-home/in-cp-pharmacy.html

**NV:** <https://myhpnmedicaid.com/member/pharmacy-benefits>

### 3 . Revision History

Date	Notes
2/2/2026	Updated NV PDL Link

Iron Chelators



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439211
<b>Guideline Name</b>	Iron Chelators
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - ALL of the following:</p> <ul style="list-style-type: none"> <li>• Diagnosis of chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndrome</li> <li>• Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with the requested medication</li> <li>• Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with the requested medication</li> </ul>	

Product Name: Brand Ferriprox, generic deferiprone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Requested medication will NOT be used for the treatment of transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia</p>	

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox, Brand Ferriprox, generic deferiprone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Isotretinoin



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512239
<b>Guideline Name</b>	Isotretinoin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name: Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Use is supported by The National Comprehensive Cancer Network (NCCN)</p>	

Product Name: Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

Product Name: Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy</li> <li>• Diagnosis of treatment resistant acne</li> </ul>	

**AND**

**2** - ONE of the following:

**2.1** Failure to an adequate trial on TWO of the following conventional therapy regimens confirmed by claims history or submission of medical records:

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

**OR**

**2.2** History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

**AND**

**3** - If the request is non-preferred\*, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred product (please document reason or special circumstance)

Notes	*PDL links are listed in Background.
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Product Name: Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - After greater than or equal to 2 months OFF therapy, persistent or recurring severe recalcitrant nodular acne is still present

**OR**

2 - Total cumulative dose for total duration of therapy is less than 150 mg/kg (document patient's dose and weight)\*

Notes

\*Will be approved up to a total of 150 mg/kg

**2 . Background**

**Benefit/Coverage/Program Information**

**PDL links**

**CO:** <https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html>

**HI:** <https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html>

**MD:** <https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html>

**NJ:** <https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html>

**NY/NY EPP:** <https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html>

**PA CHIP:** <https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP>

**RI:** <https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html>

**VA:** <https://www.uhcprovider.com/en/health-plans-by-state/virginia-health-plans/va-comm-plan-home/va-cp-pharmacy.html>

**NE:** <https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-pharmacy.html>

**NM:** <https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html>

**NV:** <https://myhpnmedicaid.com/member/pharmacy-benefits>

### 3 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Isturisa



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439213
<b>Guideline Name</b>	Isturisa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Isturisa	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Cushing's syndrome</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patient is not a candidate for pituitary surgery</li> <li>• Pituitary surgery has not been curative</li> </ul>	

Product Name:Isturisa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive response to Isturisa therapy</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Joenja (leniolisib)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422537
<b>Guideline Name</b>	Joenja (leniolisib)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Joenja	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient weighs at least 45 kg

**AND**

**3** - The patient has a diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS) confirmed by genetic mutation of either the PIK3CD or PIK3R1 gene

**AND**

**4** - Prescribed by or in consultation with immunologist

**AND**

**5** - The patient has nodal and/or extra-nodal lymphoproliferation, with the presence of greater than or equal to 1 measurable nodal lesion as confirmed by prescriber attestation of palpable diagnosis (and/or on computed tomography (CT) or MRI

**AND**

**6** - The patient has clinical findings and manifestations compatible with APDS (e.g., history of repeated oto-sinopulmonary infections, organ dysfunction [e.g., lung, liver])

**AND**

**7** - If the patient is a female of reproductive potential, pregnancy status will be confirmed prior to initiating therapy and highly effective methods of contraception will be used during treatment

**AND**

**8** - The patient is not on concurrent immunosuppressive therapy (e.g., mammalian target of rapamycin (mTOR) inhibitors, B-cell depleters, glucocorticoids [doses greater than 25 mg/day of prednisone equivalent

Product Name: Joenja	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient must have disease response with treatment as defined by stabilization of or improvement of disease signs and symptoms (e.g., decrease in the frequency and/or severity of infections, decreased lymphadenopathy, increased percentage of naïve B cells, decrease in disease-related hospitalizations)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The patient has not experienced any treatment-restricting adverse effects (e.g., severe neutropenia: ANC less than 500 cells/<math>\mu</math>L)</p>	

## 2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Juxtapid (lomitapide)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-402204
<b>Guideline Name</b>	Juxtapid (lomitapide)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Juxtapid	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of homozygous familial hypercholesterolemia (HoFH), confirmed by ONE of the following:

**2.1** Genetic testing to confirm two mutant alleles at the LDLR, APOB PCSK9, or LDLRAP1 gene locus

**OR**

**2.2** An untreated LDL greater than 500 mg/dL (or treated LDL >300 mg/dL) together with ONE of the following:

- Cutaneous or tendon xanthoma before the age of 10 years
- Untreated elevated LDL levels consistent with heterozygous FH in both parents

**AND**

**3** - Prescribed by, or in consultation with, an endocrinologist, cardiologist, or lipidologist

**AND**

**4** - The patient is currently receiving maximum tolerated statin and one other lipid lowering therapy (e.g., ezetimibe, nicotinic acid, bile acid sequestrant, fibrate, LDL apheresis), unless contraindicated or not tolerated

**AND**

**5** - The patient has history of intolerance, failure, or contraindication to PCSK9-inhibitor (e.g., Praluent, Repatha)

**AND**

**6** - The requested medication will not be used in combination with a PCSK9-inhibitor

**AND**

**7** - The patient has been counseled to follow a low-fat diet

**AND**

**8** - The patient does not have moderate or severe hepatic impairment or active liver disease

**AND**

**9** - The requested medication will not be prescribed concomitantly with strong or moderate CYP3A4 inhibitors

**AND**

**10** - If the request is for a female patient of reproductive potential, BOTH of the following:

- Must have a negative pregnancy test prior to initiating therapy
- Must be counseled to use effective contraception during treatment

**AND**

**11** - The patient's total Juxtapid dose does not exceed 60 mg (milligrams) daily

Product Name: Juxtapid	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Documentation of positive response to therapy</p>	

## 2 . Revision History

Date	Notes
9/26/2025	Added dosing max. Formatting update to step 4 if initial auth to remove “.”

Kerendia



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439215
<b>Guideline Name</b>	Kerendia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Kerendia	
Diagnosis	Chronic kidney disease (CKD)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - BOTH of the following:</p> <p>2.1 UACR (urinary albumin-to-creatinine ratio) greater than or equal to 30 mg/g</p> <p style="text-align: center;"><b>AND</b></p> <p>2.2 eGFR (estimated glomerular filtration rate) greater than or equal to 25 mL/min/1.73 m<sup>2</sup></p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Kerendia is being used to reduce the risk of at least ONE of the following:</p> <ul style="list-style-type: none"> <li>• Sustained eGFR decline</li> <li>• End-stage kidney disease</li> <li>• Cardiovascular death</li> <li>• Non-fatal myocardial infarction</li> <li>• Hospitalization for heart failure</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>4 - Serum potassium level is less than or equal to 5 mEQ/L (milliequivalents/liter) prior to initiating treatment</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - ONE of the following:</p>	

**5.1** Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

**OR**

**5.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

**AND**

**6** - Prescriber attests the patient's diabetes is being managed with a diabetes medication with proven CKD benefit [e.g., SGLT2 inhibitor (e.g., Jardiance), GLP1 receptor agonist (e.g., Ozempic)]

Product Name:Kerendia	
Diagnosis	Heart Failure with Preserved Ejection Fraction (HFpEF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of heart failure with preserved ejection fraction (HFpEF)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Ejection fraction is greater than or equal to 50%</p> <p style="text-align: center;"><b>AND</b></p>	

**3** - An eGFR of greater than or equal to 25 mL/min/1.73 m<sup>2</sup>

**AND**

**4** - Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment

**AND**

**5** - ONE of the following:

**5.1** Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)
- Maximally tolerated angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

**OR**

**5.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify allergy, contraindication, or intolerance)

**AND**

**6** - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT-2 inhibitor (e.g., Jardiance) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a SGLT-2 inhibitor (e.g., Jardiance) (please specify allergy, contraindication, or intolerance)

**AND**

**7** - ONE of the following:

- History of trial and failure to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] as confirmed by claims history or submission of medical records
- Patient has an intolerance or contraindication to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

Product Name:Kerendia	
Diagnosis	Heart Failure with mildly reduced ejection fraction (HFmrEF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of heart failure with mildly reduced ejection fraction (HFmrEF)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Ejection fraction 40% to less than 50%</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - An eGFR of greater than or equal to 25 mL/min/1.73 m<sup>2</sup></p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - ONE of the following:</p>	

**5.1** Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)
- Maximally tolerated angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

**OR**

**5.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify allergy, contraindication, or intolerance)

**AND**

**6** - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT-2 inhibitor (e.g., Jardiance) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a SGLT-2 inhibitor (e.g., Jardiance) (please specify allergy, contraindication, or intolerance)

**AND**

**7** - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) (please specify allergy, intolerance, or contraindication)

**AND**

**8** - ONE of the following:

- History of trial and failure to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] as confirmed by claims history or submission of medical records
- Patient has an intolerance or contraindication to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

Product Name:Kerendia	
Diagnosis	CKD, HFpEF, HFmrEF
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Keveyis, Ormalvi



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439216
<b>Guideline Name</b>	Keveyis, Ormalvi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Keveyis, generic dichlorphenamide, Brand Ormalvi	
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of primary hyperkalemic periodic paralysis or related variant</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Diagnosis of primary hypokalemic periodic paralysis or related variant</p>	

Product Name: Brand Keveyis, generic dichlorphenamide, Brand Ormalvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to the requested therapy</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Korlym



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439217
<b>Guideline Name</b>	Korlym
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Korlym, generic mifepristone
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of endogenous Cushing’s syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Diagnosis of type 2 diabetes mellitus</li> <li>• Diagnosis of glucose intolerance</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patient has failed surgery</li> <li>• Patient is not a candidate for surgery</li> </ul>	

Product Name: Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of a positive clinical response while on the requested therapy</p>	

## 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/5/2025	Added Nevada Formulary

Kuvan, Zelvysia



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-507575
<b>Guideline Name</b>	Kuvan, Zelvysia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Brand Kuvan, generic sapropterin, Zelvysia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of phenylketonuria (PKU)

**2 . Revision History**

Date	Notes
1/27/2026	Updated guideline name. Added Zelvysia as a target. Updated product name list and GPI table, accordingly. Removed dx header. Removed PACAID formulary as it will be standalone. No changes to clinical criteria.

Leqselvi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439220
<b>Guideline Name</b>	Leqselvi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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## 1 . Criteria

Product Name:Leqselvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1 - Diagnosis of severe alopecia areata**

**AND**

**2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)**

**AND**

**3 - Patient requesting therapy for current episode of alopecia areata**

**AND**

**4 - ONE of the following:**

- Failure to Olumiant confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

**AND**

**5 - Patient is not receiving Leqselvi in combination with any of the following:**

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

**AND**

**6 - Prescribed by or in consultation with a dermatologist**

Product Name:Leqselvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Leqselvi therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is not receiving Leqselvi in combination with any of the following:</p> <ul style="list-style-type: none"> <li>• Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib), Olumiant (baricitinib)]</li> <li>• Potent immunosuppressant (e.g., azathioprine or cyclosporine)</li> </ul>	

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Lidoderm 5% Patches



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-395193
<b>Guideline Name</b>	Lidoderm 5% Patches
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Tridacaine patch, Lidocan Patch, Brand Lidoderm, generic Lidocaine patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has one of the following diagnosis:</p> <ul style="list-style-type: none"> <li>Herpes zoster</li> <li>Post herpetic neuralgia/ neuropathy</li> </ul>	

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

## **2 . Revision History**

Date	Notes
9/22/2025	New

Litfulo



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-510414
<b>Guideline Name</b>	Litfulo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	3/1/2026
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### 1 . Criteria

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1 - Diagnosis of severe alopecia areata**

**AND**

**2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)**

**AND**

**3 - Patient requesting therapy for current episode of alopecia areata**

**AND**

**4 - ONE of the following:**

**4.1 Patient is less than 18 years of age**

**OR**

**4.2 Failure to Olumiant confirmed by claims history or submission of medical records**

**OR**

**4.3 History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)**

**AND**

**5 - Patient is not receiving Litfulo in combination with either of the following:**

- Biologic immunomodulator or Janus kinase (JAK) inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemluvio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

**AND**

**6** - Prescribed by or in consultation with a dermatologist

Product Name:Litfulo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Litfulo therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is not receiving Litfulo in combination with either of the following:</p> <ul style="list-style-type: none"> <li>• Biologic immunomodulator or Janus kinase (JAK) inhibitor [e.g., Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Leqselvi (deuruxolitinib), Nemludio (nemolizumab-ilto), Olumiant (baricitinib), Rinvoq (upadacitinib)]</li> <li>• Potent immunosuppressant (e.g., azathioprine or cyclosporine)</li> </ul>	

**2 . Revision History**

Date	Notes
2/6/2026	Updated combination examples and language with no change to clinical intent.

Livtency



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422516
<b>Guideline Name</b>	Livtency
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Livtency	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient weighs greater than 35 kilograms

**AND**

**3** - Patient has had a hematopoietic stem cell or solid organ transplant

**AND**

**4** - Patient has a documented cytomegalovirus (CMV) infection in whole blood or plasma (screening value at least 2,730 IU/mL in whole blood or at least 910 IU/mL in plasma) in TWO consecutive assessments separated by at least 1 day

**AND**

**5** - Current CMV infection is refractory (defined as failure to achieve greater than 1 log<sub>10</sub> decrease in CMV DNA level in whole blood or plasma after at least 14 days treatment) to anti-CMV treatment agents (ganciclovir, valganciclovir, cidofovir, or foscarnet), even with documented genetic mutations associated with resistance

**AND**

**6** - Medication will not be co-administered with ganciclovir or valganciclovir

**AND**

**7** - Patient will be monitored for clinically important drug interactions that could result in decreased therapeutic effect of Livtency

Product Name:Livtency	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient continues to meet the initial criteria

**AND**

2 - Disease improvement and/or stabilization or improvement in the slope of decline (greater than 1 log<sub>10</sub> decrease in CMV DNA level in whole blood or plasma after 14 days or longer treatment)

**AND**

3 - Patient has not experienced any treatment-restricting adverse effects (e.g., dysgeusia, diarrhea, nausea, and recurrence of underlying disease)

**AND**

4 - Patient is not a non-responder (resistant) to Livtency

**2 . Revision History**

Date	Notes
10/21/2025	New

Long Acting Narcotics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512240
<b>Guideline Name</b>	Long Acting Narcotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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### 1 . Criteria

Product Name:fentanyl patches	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteroidal analgesics, or PRN (as needed) dosing with short-acting opioid</p> <p style="text-align: center;"><b>AND</b></p>	

2 - Patient requires continuous opioid administration

**AND**

3 - Prescriber has checked the Nevada State Board of Pharmacy's (BOP) Prescription Monitoring Program (PMP) prior to prescribing narcotic analgesics

**AND**

4 - If transitioning from another opioid, daily morphine equivalent doses are used to calculate the appropriate fentanyl patch dose

Product Name: tramadol ER, Conzip	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: generic morphine sulfate ER/CR tabs, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, methadose tablet for oral susp, methadone tablet for oral susp, Belbuca, Brand Butrans, generic buprenorphine patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, methadose tablet for oral susp, methadone tablet for oral susp, tramadol ER, Conzip, Belbuca, Brand Butrans, generic buprenorphine patch

Approval Length	3 month(s)
Guideline Type	Quantity Limit

**Approval Criteria**

1 - The patient has a diagnosis of terminal cancer

**OR**

2 - All of the following:

2.1 The patient is 18 years of age or older

**AND**

2.2 The requested medication will be used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment

**AND**

2.3 Documentation that alternative agents (e.g., non-opioid analgesics or immediate-release

opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain

Product Name: generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, methadose tablet for oral susp, methadone tablet for oral susp, tramadol ER, Conzip, Belbuca, Brand Butrans, generic buprenorphine patch

Diagnosis	Requests exceeding Morphine Milligram Equivalents (MME)
Approval Length	For patients less than 18 years of age, approval length is 3 months; For patients greater than or equal to 18 years of age, approval length is 12 months
Guideline Type	DUR

**Approval Criteria**

1 - One of the following:

1.1 All of the following:

- The patient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber
- Pain cannot be controlled through the use of non-opioid therapy [e.g., acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.]
- The lowest effective dose is being prescribed
- A pain contract is on file

**OR**

1.2 One of the following:

- Patient has cancer/malignancy related pain
- Patient is post-surgery with an anticipated prolonged recovery (greater than 3 months)
- Patient is receiving palliative care, hospice, or end-of-life care
- Patient is residing in a long-term care facility
- Patient is receiving treatment for HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)
- Prescribed by, or in consultation with, a pain specialist

## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link.

Long-Acting Injectable (LAI) Antipsychotics



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512241
<b>Guideline Name</b>	Long-Acting Injectable (LAI) Antipsychotics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name: Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Invega Sustenna, Perseris, Brand Risperdal Consta, generic risperidone ER IM, Uzedy, Zyprexa Relprevv	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - If patient is treatment naive to long acting injectables, documentation of tolerance to the oral formulation prior to transitioning to the requested medication</p>	

**AND**

**2** - If the patient is less than 18 years of age, one of the following:

**2.1** Patient has been discharged from an institutional facility within the past 6 months\* (please document name of discharge institution and date of discharge)

**OR**

**2.2** Patient has been started on the requested medication within the past 6 months and is stabilized\* (please document start date of medication)

**OR**

**2.3** All of the following:

**2.3.1** The requested medication is prescribed by or in consultation with a child psychiatrist

**AND**

**2.3.2** The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

**AND**

**2.3.3** Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

**2.3.3.1** For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

**OR**

**2.3.3.2** For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

**AND**

**2.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

**AND**

**3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Invega Trinza

Approval Length

12 month(s)

Guideline Type

Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of schizophrenia

**AND**

**2** - The patient has been stabilized on once-monthly paliperidone palmitate injection (Invega Sustenna) for at least four months with the two most recent doses of the once-monthly injection being the same strength

**AND**

**3** - The patient is 18 years of age or older

<b>AND</b>
<b>4</b> - The requested dose is one injection every three months

Product Name: Invega Hafyera	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of schizophrenia</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient has been stabilized on once-monthly paliperidone palmitate extended-release injectable suspension (Invega Sustenna) for at least four months, the two most recent doses of the once-monthly injection being the same strength or one dose of three-month IM paliperidone (Invega Trinza)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The requested dose is one injection every six months</p>	

Product Name: Invega Hafyera	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation confirming a positive response from therapy</p>	

## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Lupkynis



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439223
<b>Guideline Name</b>	Lupkynis
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of active lupus nephritis</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Provider attests to ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis is biopsy proven</li> <li>• Biopsy is contraindicated in the patient</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - Provider attests to ONE of the following:</b></p> <p><b>3.1</b> Clinical progression (e.g., worsening of proteinuria or serum creatinine) after 3 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p><b>3.2</b> Failure to respond after 6 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>5 - Patient is NOT receiving Lupkynis in combination with either of the following:</b></p>	

- Cyclophosphamide
- Benlysta (belimumab)

**AND**

**6** - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

Product Name:Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Lupkynis therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient is NOT receiving Lupkynis in combination with either of the following:</p> <ul style="list-style-type: none"> <li>• Cyclophosphamide</li> <li>• Benlysta (belimumab)</li> </ul> <p style="text-align: center;"><b>AND</b></p>	

4 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Lynkuet, Veozah



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-510421
<b>Guideline Name</b>	Lynkuet, Veozah
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

**Guideline Note:**

Effective Date:	3/1/2026
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**1 . Criteria**

Product Name:Lynkuet, Veozah	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <p><b>2.1 Failure (after a 30-day trial) to ONE of the following as confirmed by claims history or submission of medical records:</b></p> <ul style="list-style-type: none"> <li>• Hormonal therapy (e.g., estradiol, Premarin, Prempro)</li> <li>• Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):</b></p> <ul style="list-style-type: none"> <li>• Hormonal therapy (e.g., estradiol, Premarin, Prempro)</li> <li>• Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - Patient has received baseline hepatic laboratory tests to rule out the presence of underlying liver disease</b></p>	

Product Name:Lynkuet, Veozah	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline)

**AND**

2 - Patient has received periodic evaluation of hepatic laboratory tests to rule out liver injury associated with the requested medication use

**2 . Revision History**

Date	Notes
2/6/2026	Updated GL name to Lynkuet, Veozah. Removed PACAID. Added Lynkuet as a target and updated GPI and product name list. Updated reauth criteria.

Medications for the Treatment of Acne



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512242
<b>Guideline Name</b>	Medications for the Treatment of Acne
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name: Brand Acanya, Brand Onexton, generic clindamycin/benzoyl peroxide gel, Azelex, benzoyl peroxide 2.5%, 5%, and 10% (all Rx and OTC products), clindamycin 1% (all Rx and OTC products), Brand Benzamycin, generic erythromycin/benzoyl peroxide gel, Brand Aczone, generic dapson gel, Amzeeq, Ery Pads, erythromycin 2%, sodium sulfacetamide/sulfur (all Rx and OTC products), sodium sulfacetamide lotion/wash/gel/shampoo (all Rx and OTC products), Winlevi, Brand Differin, Adapalene, generic adapalene, Brand Atralin, Brand Retin-A, generic tretinoin, Altreno, Brand Retin-A Micro, generic tretinoin microsphere, Brand Ziana, generic clindamycin/tretinoin, Arazlo, Fabior, Tazarotene foam, Brand Tazorac, generic tazarotene, Brand Epiduo, Brand Epiduo Forte, Adapalene/benzoyl peroxide, generic adapalene/benzoyl peroxide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - One of the following:

1.1 Patient is less than 21 years of age

**OR**

1.2 Patient is 21 years of age or older and has a diagnosis of moderate to severe acne (Grade III or higher)

**AND**

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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**2 . Revision History**

Date	Notes
2/3/2026	Updated PDL Link

Mepron



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439225
<b>Guideline Name</b>	Mepron
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis [e.g., HIV (human immunodeficiency virus)] warranting PCP (pneumocystis jirovecii pneumonia) infection prophylaxis

**AND**

2 - The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone (please specify intolerance or contraindication)

Product Name: Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Treatment
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of mild to moderate pneumonia caused by pneumocystis jirovecii</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Failure of trimethoprim-sulfamethoxazole (TMP-SMX) confirmed by claims history or submitted medical records</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 History of intolerance or contraindication to TMP-SMX (please specify intolerance or contraindication)</p>	

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/5/2025	Added Nevada Formulary

Movement Disorder Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422550
<b>Guideline Name</b>	Movement Disorder Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Austedo, Austedo XR, Ingrezza	
Diagnosis	Chorea Associated with Huntington’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chorea associated with Huntington’s disease</p>	

<b>AND</b>
<b>2</b> - Patient is 18 years of age or older
<b>AND</b>
<b>3</b> - Prescribed by or in consultation with a neurologist

Product Name:Austedo, Austedo XR, Ingrezza	
Diagnosis	Tardive Dyskinesia (TD)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Austedo/Austedo XR: diagnosis of Tardive Dyskinesia (TD)</li> <li>• Ingrezza: diagnosis of severe Tardive Dyskinesia (TD)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by or in consultation with a neurologist or psychiatrist</p> <p style="text-align: center;"><b>AND</b></p>	

**4 - ONE of the following:**

- Persistent symptoms of TD despite a trial of dose reduction, tapering or discontinuation of the offending medication
- The patient is NOT a candidate for trial of dose reduction, tapering or discontinuation of the offending medication

Product Name:Austedo, Austedo XR, Ingrezza	
Diagnosis	Chorea Associated with Huntington’s Disease, Tardive Dyskinesia (TD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

**2 . Revision History**

Date	Notes
10/22/2025	New program

Mozobil



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-439226
<b>Guideline Name</b>	Mozobil
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Mozobil, generic plerixafor
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Diagnosis	Hematopoietic Stem Cell Mobilization
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patients with non-Hodgkin’s lymphoma (NHL) who will be undergoing autologous hematopoietic stem cell (HSC) transplantation</li> <li>• Patients with multiple myeloma (MM) who will be undergoing autologous HSC transplantation</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>2 - Used in combination with granulocyte-colony stimulating factor (G-CSF) [e.g., Zarxio (filgrastim)]</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by or in consultation with a hematologist/oncologist</p>	

Product Name: Brand Mozobil, generic plerixafor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p>	

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name: Brand Mozobil, generic plerixafor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to the requested therapy</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Added Nevada Formulary

Mulpleta



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-485191
<b>Guideline Name</b>	Mulpleta
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Mulpleta	
Diagnosis	Thrombocytopenia
Approval Length	1 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of thrombocytopenia

**AND**

2 - Patient has chronic liver disease

**AND**

3 - Patient is scheduled to undergo a procedure

**2 . Revision History**

Date	Notes
12/18/2025	Removed IN from formularies - see state specific GL-475187 for IN 1 .1.26. No other changes to guideline.

Multaq



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-438187
<b>Guideline Name</b>	Multaq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Paroxysmal Atrial Fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

**AND**

1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

**AND**

1.3 Patient does NOT have New York Heart Association (NYHA) Class IV heart failure

**AND**

1.4 Patient does NOT have symptomatic heart failure with recent decompensation requiring hospitalization

**OR**

2 - For continuation of current therapy

**2 . Revision History**

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical changes.
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Multiple Sclerosis (MS) Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512243
<b>Guideline Name</b>	Multiple Sclerosis (MS) Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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### 1 . Criteria

Product Name: Brand Ampyra, generic dalfampridine	
Approval Length	Initial authorization approval length is 3 month; Reauthorization approval length is 12 months
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of MS (multiple sclerosis)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The requested medication is being used to improve the patient’s walking speed

**AND**

**3** - The requested medication is being prescribed by, or in consultation with, a neurologist

**AND**

**4** - The patient is ambulatory and has an EDSS (expanded disability status scale) score between 2.5 and 6.5

**AND**

**5** - The patient does NOT have moderate to severe renal dysfunction [creatinine clearance (CrCl) less than 50 ml/min (milliliters per minute)]

**AND**

**6** - The patient does NOT have a history of seizures

**AND**

**7** - The patient is NOT currently pregnant or attempting to conceive

<b>Product Name:</b> Lemtrada	
<b>Approval Length</b>	12 month(s)
<b>Guideline Type</b>	Prior Authorization
<b>Approval Criteria</b>	
<p><b>1</b> - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses]</p>	

**AND**

**2** - One of the following:

**2.1** Both of the following:

**2.1.1** The patient has NOT been previously treated with Lemtrada (alemtuzumab)

**AND**

**2.1.2** The patient has had failure after a trial of at least four weeks; a contraindication, or intolerance to two of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Extavia (interferon beta-1b)
- Gilenya (fingolimod)
- Mavenclad (cladribine)
- Mayzent (siponimod)
- Ocrevus (ocrelizumab)
- Plegridy (peginterferon beta-1a)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Tysabri (natalizumab)
- Zinbryta (daclizumab)

**OR**

**2.2** Both of the following:

- The patient has been previously treated with Lemtrada (alemtuzumab)
- The patient has had at least 12 months elapsed or will have elapsed since the most recent treatment with Lemtrada (alemtuzumab)

**AND**

**3** - The requested medication will NOT be used in combination with another disease-modifying therapy for MS

Product Name:Mavenclad	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses]</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <p>2.1 Both of the following:</p> <p>2.1.1 The patient has NOT been previously treated with Mavenclad (cladribine)</p> <p style="text-align: center;"><b>AND</b></p> <p>2.1.2 The patient has had failure after a trial of at least four weeks; a contraindication, or intolerance to, two of the following disease-modifying therapies for MS:</p> <ul style="list-style-type: none"> <li>• Aubagio (teriflunomide)</li> <li>• Avonex (interferon beta-1a)</li> <li>• Betaseron (interferon beta-1b)</li> <li>• Copaxone/Glatopa (glatiramer acetate)</li> <li>• Extavia (interferon beta-1b)</li> <li>• Gilenya (fingolimod)</li> <li>• Lemtrada (alemtuzumab)</li> <li>• Mayzent (siponimod)</li> <li>• Ocrevus (ocrelizumab)</li> <li>• Plegridy (peginterferon beta-1a)</li> <li>• Rebif (interferon beta-1a)</li> <li>• Tecfidera (dimethyl fumarate)</li> <li>• Tysabri (natalizumab)</li> <li>• Zinbryta (daclizumab)</li> </ul>	

**OR**

**2.2 Both of the following:**

- The patient has been previously treated with Mavenclad (cladribine)
- The patient has NOT already received the FDA (Food and Drug Administration)-recommended lifetime limit of two treatment courses (or four treatment cycles total) of cladribine

**AND**

**3 - The requested medication will NOT be used in combination with another disease-modifying therapy for MS**

Product Name: Ocrevus, Ocrevus Zunovo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - The patient has a confirmed diagnosis of MS (multiple sclerosis) as documented by laboratory report (i.e., magnetic resonance imaging (MRI)) and one of the following:</b></p> <p><b>1.1 The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [i.e., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses or clinically isolated syndrome (CIS)]</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2 The patient has a diagnosis of primary progressive MS (PPMS) and both of the following:</b></p> <ul style="list-style-type: none"> <li>• Patient is less than 65 years of age</li> <li>• Patient has an EDSS (expanded disability status scale) score of less than or equal to 6.5</li> </ul>	

**AND**

**2** - The patient is at least 18 years of age

**AND**

**3** - The patient has been screened for the presence of HBV prior to initiating treatment and does NOT have active disease [i.e., positive Hepatitis B surface antigen (HBsAg) and anti-HBV tests]

**AND**

**4** - The patient has had baseline serum immunoglobulins assessed

**AND**

**5** - The patient will NOT receive live or live-attenuated vaccines while on therapy or within four weeks prior to initiation of treatment

**AND**

**6** - The patient does NOT have an active infection

**AND**

**7** - The requested medication will be used as single agent therapy

**AND**

**8** - If the request is for a non-preferred product\*, the patient has had a trial of one preferred product

Notes

\*PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name:Ocrevus, Ocrevus Zunovo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient has NOT received a dose of Ocrevus (ocrelizumab) within the past five months</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Absence of unacceptable toxicity from the drug (examples of unacceptable toxicity include: severe infusion reactions, severe infections, progressive multifocal leukoencephalopathy malignancy, hypogammaglobulinemia, immune-mediated colitis, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Continuous monitoring of response to therapy indicates a beneficial response</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - If the patient has a diagnosis of primary progressive MS (PPMS), patient continues ambulatory, defined as an EDSS (expanded disability status scale) score of less than 7.5</p>	

Product Name:Ponvory	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses or clinically isolated syndrome (CIS)]

**AND**

**2** - The patient will NOT be initiating therapy after previous treatment with Lemtrada (alemtuzumab)

**AND**

**3** - Prescribed by, or in consultation with, neurologist

**AND**

**4** - One of the following:

**4.1** The requested medication is being used for continuation of therapy

**OR**

**4.2** The patient has had failure after a trial of at least four weeks, contraindication, or intolerance to at least one of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Tysabri (natalizumab)
- Tecfidera (dimethyl fumarate)
- Aubagio (teriflunomide)
- Gilenya (fingolimod)

Product Name:Ponvory

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by, or in consultation with, neurologist</p>	

Product Name: Avonex, Betaseron, Briumvi, Brand Copaxone, Glatopa, generic glatiramer, Kesimpta, Plegridy, Rebif, Tysabri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of multiple sclerosis (MS)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - If the request is for a non-preferred product*, the patient has had a trial of one preferred product</p>	
Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Brand Aubagio, generic Brand Tecfidera, generic dimethyl fumarate, Brand Gilenya, generic fingolimod, Bafiertam, Mayzent, Vumerity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of multiple sclerosis (MS)

**AND**

2 - If the request is for a non-preferred product\*, the patient has had a trial of two preferred products

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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**2 . Revision History**

Date	Notes
2/3/2026	Updated PDL Link

Myalept



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442188
<b>Guideline Name</b>	Myalept
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Myalept	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Used as an adjunct to diet modification</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by an endocrinologist</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Patient has at least ONE of the following:</p> <p>4.1 Diabetes mellitus or insulin resistance with persistent hyperglycemia (hemoglobin A1C greater than 7.0%) despite BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Dietary intervention</li> <li>• Optimized insulin therapy at maximum tolerated doses</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>4.2 Persistent hypertriglyceridemia (triglycerides greater than 200 milligrams per deciliter) despite BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Dietary intervention</li> <li>• Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses</li> </ul>	

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Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Myalept therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Used as an adjunct to diet modification</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by an endocrinologist</p>	

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Mycapssa



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442189
<b>Guideline Name</b>	Mycapssa
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ALL of the following:</p> <p>1.1 Diagnosis of acromegaly by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Serum GH (growth hormone) level &gt; 1 ng/mL (nanogram/milliliter) after a 2-hour oral glucose tolerance test (OGTT) at time of diagnosis</li> <li>• Elevated serum IGF-1 (insulin-like growth factor-1) levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>1.2 ONE of the following:</p> <p>1.2.1 Inadequate response to ONE of the following:</p> <ul style="list-style-type: none"> <li>• Surgical resection</li> <li>• Pituitary irradiation</li> <li>• Dopamine agonist (e.g., bromocriptine, cabergoline) therapy</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>1.2.2 Not a candidate for ALL of the following:</p> <ul style="list-style-type: none"> <li>• Surgical resection</li> <li>• Pituitary irradiation</li> <li>• Dopamine agonist (e.g., bromocriptine, cabergoline) therapy</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>1.3 Patient has responded to and tolerated treatment with ONE of the following somatostatin analogs:</p> <ul style="list-style-type: none"> <li>• Sandostatin (octreotide) or Sandostatin LAR</li> </ul>	

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<ul style="list-style-type: none"> <li>Somatuline Depot (lanreotide) [Note: Somatuline Depot (lanreotide) might not be covered on your pharmacy prescription drug benefit. Coverage might be available on your medical benefit.]</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>1.4</b> The provider has submitted clinical justification why the patient is unable to be maintained on current octreotide or lanreotide therapy*</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2</b> - Patient is currently on Mycapssa therapy for acromegaly</p>	
Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity.

Product Name: Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of a positive clinical response to Mycapssa therapy</p>	

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Narcolepsy Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-397257
<b>Guideline Name</b>	Narcolepsy Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of narcolepsy</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Excessive sleepiness associated with shift work disorder
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of excessive sleepiness associated with shift work disorder</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Excessive sleepiness associated with shift work disorder
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Obstructive Sleep Apnea (OSA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Patient has a diagnosis of obstructive Sleep Apnea (OSA) defined by one of the following:</b></p> <p><b>1.1</b> The patient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> Both of the following:</p> <p><b>1.2.1</b> Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2.2</b> One of the following signs/symptoms are present:</p> <ul style="list-style-type: none"> <li>• Daytime sleepiness</li> <li>• Nonrestorative sleep</li> <li>• Fatigue</li> <li>• Insomnia</li> <li>• Waking up with breath holding, gasping, or choking</li> <li>• Habitual snoring noted by a bed partner or other observer</li> <li>• Observed apnea</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Both the following:</b></p> <p><b>2.1</b> The patient has used a standard treatment(s) for the underlying obstruction for one month or longer [e.g., continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP)]</p>	

**AND**

**2.2** The patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

**AND**

**3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Sunosi	
Diagnosis	Obstructive Sleep Apnea (OSA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has a diagnosis of obstructive Sleep Apnea (OSA) defined by one of the following:</p> <p><b>1.1</b> The patient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> Both of the following:</p> <p><b>1.2.1</b> Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>AND</b></p>	

**1.2.2** One of the following signs/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by a bed partner or other observer
- Observed apnea

**AND**

**2** - Both the following:

**2.1** The patient has used a standard treatment(s) for the underlying obstruction for one month or longer [e.g., continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP)]

**AND**

**2.2** The patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

**AND**

**3** - The patient has had trial and failure, contraindication, or intolerance to both of the following:

- Provigil
- Nuvigil

Product Name: Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil, Sunosi	
Diagnosis	Obstructive Sleep Apnea (OSA)
Approval Length	Approval length for Sunosi is 6 months; all other products approval length is 12 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to therapy

**AND**

2 - The patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction [e.g., continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP)]

Product Name:Sunosi	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient has had trial and failure, contraindication, or intolerance to both of the following:</p> <ul style="list-style-type: none"> <li>• Provigil</li> <li>• Nuvigil</li> </ul>	

Product Name:Sunosi	
Diagnosis	Narcolepsy

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Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

Product Name:Wakix	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient is 18 years of age and older</p>	

Product Name:Wakix	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

Product Name: Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (Narcolepsy Type 1)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient has present symptoms of cataplexy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient has symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The requested medication is prescribed by or in consultation with one of the following:</p> <ul style="list-style-type: none"> <li>• A neurologist</li> <li>• A psychiatrist</li> <li>• A Sleep Medicine Specialist</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - The patient meets the FDA (Food and Drug Administration) approved minimum age for the requested medication and indication</p>	

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name: Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - One of the following:</p> <p><b>1.1</b> Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with therapy</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy</p>	

Product Name: Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (Narcolepsy Type 2)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p>	

**1** - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

**AND**

**2** - The symptoms of cataplexy are absent in the patient

**AND**

**3** - The patient has symptoms of excessive daytime sleepiness (e.g., irrepensible need to sleep or daytime lapses into sleep)

**AND**

**4** - Patient has trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to both of the following:

- Provigil or Nuvigil
- Sunosi

**AND**

**5** - One of the following

**5.1** The patient has trial and failure, contraindication, or intolerance to an amphetamine (e.g., amphetamine, dextroamphetamine) or methylphenidate-based stimulant

**OR**

**5.2** The patient has history of or potential for substance use disorder

**AND**

**6** - The requested medication is prescribed by or in consultation with one of the following:

<ul style="list-style-type: none"> <li>• A neurologist</li> <li>• A psychiatrist</li> <li>• A Sleep Medicine Specialist</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>7 - The patient meets the FDA (Food and Drug Administration) approved minimum age for the requested medication and indication</p> <p style="text-align: center;"><b>AND</b></p> <p>8 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>
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Product Name: Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy</p>	

Product Name: Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of idiopathic hypersomnia with all of the following:

**1.1** The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

**AND**

**1.2** The absence of cataplexy

**AND**

**1.3** Fewer than two sleep onset REM periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques, or no SOREMPs if the REM sleep latency on the preceding polysomnogram was less than 15 minutes

**AND**

**1.4** One of the following:

- A mean sleep latency of less than or equal to 8 minutes
- Total 24-hour sleep time greater than or equal to 660 minutes

**AND**

**1.5** Other causes of sleepiness have been ruled out

**AND**

**1.6** The medication is prescribed by or in consultation with one of the following:

- A neurologist
- A psychiatrist
- A Sleep Medicine Specialist

**AND**

1.7 Patient is at least 18 years old

Product Name: Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy</p>	

## 2 . Revision History

Date	Notes
9/17/2025	New guideline

Neurokinin-1 Antagonists and Combinations



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-422527
<b>Guideline Name</b>	Neurokinin-1 Antagonists and Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:generic aprepitant, brand Emend, Aponvie, Cinvanti	
Approval Length	6 month(s)
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - The requested medication is being used for an FDA-approved indication</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by an oncologist or in consultation with an oncologist</p>	

**AND**

**3 - ONE of the following:**

- The patient is 18 years of age or older
- The patient is 12 years of age or older, the requested medication is aprepitant (Emend) and the patient is diagnosed with nausea and vomiting caused by chemotherapy

**AND**

**4 - It is medically necessary for the patient to exceed the quantity limit (e.g., duration of chemotherapy cycle)**

## **2 . Revision History**

Date	Notes
10/21/2025	New program

Niemann-Pick Disease Type C (NPC) Agents



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-458419
<b>Guideline Name</b>	Niemann-Pick Disease Type C (NPC) Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Aqneursa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has diagnosis of Niemann-Pick disease type C (NPC) genetically confirmed by mutation analysis of NPC1 andNPC2 genes</p>	

**AND**

**2** - The requested medication is being used to treat neurological manifestations of NPC

**AND**

**3** - Patient weighs at least 15 kg (kilograms)

**AND**

**4** - The requested medication is being dosed per FDA-(Food and Drug Administration) label based on actual body weight

**AND**

**5** - If the request is for a female of reproductive potential, both of the following:

- The patient has a negative pregnancy test prior to initiating the requested medication
- The patient has been counseled to use effective contraception during treatment and for seven days after last dose if discontinued

**AND**

**6** - The requested medication will not be used in combination with Miplyffa

**AND**

**7** - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, or other specialist with advanced knowledge in treating NPC

Product Name:Miplyffa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has diagnosis of Niemann-Pick disease type C (NPC) genetically confirmed by mutation analysis of NPC1 andNPC2 genes</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The requested medication is being used to treat neurological manifestations of NPC</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient is at least 2 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The requested medication is being dosed (in combination with miglustat) per FDA-(Food and Drug Administration) label based on patient's actual body weight</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - The requested medication will not be used in combination with Aqneursa</p> <p style="text-align: center;"><b>AND</b></p> <p><b>6</b> - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, or other specialist with advanced knowledge in treating NPC</p>	

Product Name:Aqneursa, Miplyffa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient continues to meet initial authorization criteria

**AND**

2 - Documentation of positive response to therapy

**2 . Revision History**

Date	Notes
12/10/2025	New guideline

Nityr



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442190
<b>Guideline Name</b>	Nityr
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Nityr	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of hereditary tyrosinemia type 1</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Non-Preferred Drugs



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512244
<b>Guideline Name</b>	Non-Preferred Drugs
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name:Non-Preferred Drugs	
Approval Length	*Patients discharged from an institution on a non-preferred psychotropic and/or non-preferred anti-depressant medication(s), approval length is up to 6 month(s) from discharge date; otherwise, approval length is 12 month(s)
Guideline Type	Administrative
<p><b>Approval Criteria</b></p> <p>1 - The patient has been discharged from an institution on a non-preferred psychotropic and/or non-preferred anti-depressant medication(s) within the past 6 months* (please document date of discharge)</p>	

**OR**

**2** - All of the following:

**2.1** One of the following:

**2.1.1** If the requested medication is being prescribed for a psychiatric condition [defined as a mental disorder for which criteria are prescribed in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA)], all of the following:

**2.1.1.1** Submission of medical records confirming one of the following:

- The patient has an FDA (Food and Drug Administration) approved indication for the requested medication
- The use of the requested medication to treat the patient's condition is supported by medical or scientific evidence

**AND**

**2.1.1.2** The prescriber is one of the following:

- A psychiatrist
- A physician assistant under the supervision of a psychiatrist
- An Advanced Practice Registered Nurse (APRN) who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120
- A primary care provider that is providing care in consultation with any practitioner listed above, and the closest practitioner above who participates in the network plan of the patient is located 60 miles or more from the residence of the patient

**AND**

**2.1.1.3** One of the following:

**2.1.1.3.1** Allergy to all preferred medications within the same class

**OR**

**2.1.1.3.2** Contraindication to or drug-to-drug interaction with all preferred medications within the same class

**OR**

**2.1.1.3.3** History of unacceptable/toxic side effects to all preferred medications within the same class

**OR**

**2.1.1.3.4** Therapeutic failure of two preferred medications within the same class (If there are not two preferred medications within the same class, therapeutic failure only needs to occur on the one preferred medication), UNLESS the requested medication is for an atypical or typical antipsychotic or anticonvulsant then the patient demonstrated therapeutic failure on one preferred agent

**OR**

**2.1.1.3.5** The requested medication has an indication which is unique to a non-preferred agent, and is supported by peer-reviewed literature or an FDA-approved indication

**OR**

**2.1.1.3.6** Both of the following:

- The prescriber believes based on the medical history of the patient or reasonably expects each preferred drug within the same class to be ineffective at treating the psychiatric condition
- Submission of supportive clinical documentation demonstrating the reasoning for use of the requested medication

**OR**

**2.1.2** Otherwise, one of the following:

- Allergy to all preferred medications within the same class
- Contraindication to or drug-to-drug interaction with all preferred medications within the same class
- History of unacceptable/toxic side effects to all preferred medications within the same class

- Therapeutic failure of two preferred medications within the same class (If there are not two preferred medications within the same class, therapeutic failure only needs to occur on the one preferred medication), UNLESS the requested medication is for an atypical or typical antipsychotic, anticonvulsant, antidiabetic, dopamine precursor, injectable multiple sclerosis or non-sedating H1 blocker medication, then the patient demonstrated therapeutic failure on one preferred agent
- The requested medication has an indication which is unique to a non-preferred agent, and is supported by peer-reviewed literature or an FDA-approved indication

**AND**

**2.2** If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, one of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)
- The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records
- The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient
- Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

**AND**

**2.3** If the request is for a generic when there is a brand available and the brand is the preferred formulation, one of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity)
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records
- The generic is being requested because transition to the brand could result in destabilization of the patient
- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances)

**AND**

**2.4** If the request is for an oral non-solid dosage form (e.g., suspension) when there is an equivalent solid dosage form available, one of the following:

- Patient is unable to swallow a solid dosage form
- Patient utilizes a feeding tube for medication administration
- Request is for a nebulized formulation of an inhaled agent for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: PA Required Medications For a New Indication Not Addressed in Drug Specific Guideline

Approval Length | 12 month(s)

Guideline Type | Administrative

**Approval Criteria**

1 - Both of the following:

1.1 Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert)

**AND**

1.2 All of the following labeling requirements have been met:

1.2.1 All requirements listed in the "Indications and Use" have been met (e.g., pre-requisite treatment, any testing requirements have been met, etc.)

**AND**

1.2.2 Prescribed medication is approved for the patient's age

**AND**

**1.2.3** “Dosage and Administration” section of the prescribing information (or package insert) has been met

**AND**

**2** - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan’s program

**AND**

**3** - If the requested medication is non-preferred, patient meets the non-preferred criteria as applicable

Notes	These criteria come from PA Required Medications For a New Indication Not Addressed in Drug Specific Guideline policy.
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## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Northera



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442191
<b>Guideline Name</b>	Northera
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Northera, generic droxidopa	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) as defined by ONE of the following when an upright position is assumed or when using a head-up tilt-table testing at an angle of at least 60 degrees:</p> <ul style="list-style-type: none"> <li>• At least a 20 millimeters of mercury (mm Hg) fall in systolic pressure</li> <li>• At least a 10 mm Hg fall in diastolic pressure</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - nOH caused by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Primary autonomic failure (e.g., Parkinson’s disease, multiple system atrophy, and pure autonomic failure)</li> <li>• Dopamine beta-hydroxylase deficiency</li> <li>• Non-diabetic autonomic neuropathy</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Diagnostic evaluation has excluded other causes associated with orthostatic hypotension (e.g., congestive heart failure, fluid restriction, malignancy)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - The patient has tried at least TWO of the following non-pharmacologic interventions:</p> <ul style="list-style-type: none"> <li>• Discontinuation of drugs which can cause orthostatic hypotension [e.g., diuretics, antihypertensive medications (primarily sympathetic blockers), anti-anginal drugs (nitrates), alpha-adrenergic antagonists, and antidepressants]</li> <li>• Raising the head of the bed 10 to 20 degrees</li> <li>• Compression garments to the lower extremities or abdomen</li> <li>• Physical maneuvers to improve venous return (e.g., regular modest-intensity exercise)</li> <li>• Increased salt and water intake, if appropriate</li> <li>• Avoiding precipitating factors (e.g., overexertion in hot weather, arising too quickly from supine to sitting or standing)</li> </ul>	

**AND**

**5** - No previous diagnosis of supine hypertension

**AND**

**6** - Prescribed by or in consultation with **ONE** of the following specialists:

- Cardiologist
- Neurologist
- Nephrologist

**AND**

**7** - **ONE** of the following:

**7.1** Failure (after a trial of at least 30 days) of **BOTH** of the following confirmed by claims history or submitted medical records:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

**OR**

**7.2** History of contraindication or intolerance to **BOTH** of the following:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

Product Name: Brand Northera, generic droxidopa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to the requested therapy

**AND**

2 - Physiological countermeasures for neurogenic orthostatic hypotension (nOH) continue to be employed

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Nuzyra



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442192
<b>Guideline Name</b>	Nuzyra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Nuzyra tablets	
Guideline Type	Prior Authorization

**Approval Criteria**

1 - For continuation of therapy upon hospital discharge

**OR**

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

**OR**

3 - ALL of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

**AND**

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

**AND**

3.3 ONE of the following:

3.3.1 Failure to THREE of the following antibiotics or antibiotic regimens, as confirmed by claims history or submission of medical records:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

**OR**

**3.3.2** History of intolerance or contraindication to ALL of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

**OR**

**4** - ALL of the following:

**4.1** ONE of the following diagnoses:

**4.1.1** BOTH of the following:

**4.1.1.1** Acute bacterial skin and skin structure infections

**AND**

**4.1.1.2** Infection caused by methicillin-resistant *Staphylococcus aureus* (MRSA) documented by culture and sensitivity report

**OR**

**4.1.2** BOTH of the following:

**4.1.2.1** Empirical treatment of a patient with acute bacterial skin and skin structure infections

**AND**

**4.1.2.2** Presence of MRSA infection is likely

**AND**

**4.2** ONE of the following:

**4.2.1** Failure to linezolid (generic Zyvox) as confirmed by claims history or submission medical records

**OR**

**4.2.2** History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

**AND**

**4.3** ONE of the following:

**4.3.1** Failure to ONE of the following antibiotics as confirmed by claims history or submission medical records:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

**OR**

**4.3.2** History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- A tetracycline
- Clindamycin

**OR**

**5** - ALL of the following:

**5.1** Diagnosis of acute bacterial skin and skin structure infections

**AND**

**5.2** Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

**AND**

**5.3 ONE of the following:**

**5.3.1** Failure to THREE of the following antibiotics confirmed by claims history or submission medical records:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

**OR**

**5.3.2** History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

**OR**

**6** - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Notes	Authorization duration for CABP and acute bacterial skin and skin structure infections will be issued for up to 14 days. For all IDSA recognized indications, authorization duration is based on provider and IDSA recommended treatment durations, up to 6 months.
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## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary



Ocaliva (obeticholic acid), Iqirvo (elafibranor), Livdelzi (seladelpar)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-504211
<b>Guideline Name</b>	Ocaliva (obeticholic acid), Iqirvo (elafibranor), Livdelzi (seladelpar)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Ocaliva, Iqirvo, Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has a diagnosis of primary biliary cholangitis (PBC) confirmed by TWO of the following:

- Biochemical evidence of cholestasis with an alkaline phosphatase (ALP) elevation
- Presence of anti-mitochondrial antibodies (AMAs) or other PBC-specific antibodies (anti-sp100, anti gp210, Anti-Kelch-Like 12, and/or Anti-Hexokinase 1)
- Histopathologic evidence of nonsuppurative cholangitis and destruction of small or medium bile ducts on liver biopsy

**AND**

**3** - ONE of the following:

- The requested medication is being prescribed in combination with ursodeoxycholic acid (UDCA) due to inadequate response to trial of at least 12 months with UDCA
- The patient has a history of intolerance or contraindication to UDCA

**AND**

**4** - Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or other specialist with advanced knowledge of treating PBC

**AND**

**5** - The prescriber attests that the patient does not have any FDA-labeled contraindications to the requested medication (e.g., complete biliary obstruction, decompensated cirrhosis)

Product Name:Ocaliva, Iqirvo, Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - The patient continues to meet the initial authorization criteria	

**AND**

**2** - Documentation of positive response to therapy

## **2 . Revision History**

Date	Notes
1/20/2026	Specified Anti-Hexokinase 1 in initial auth. Deleted ";" at the end of first bullet point in step 3.

Opfolda



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442194
<b>Guideline Name</b>	Opfolda
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Opfolda	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of late-onset Pompe disease as confirmed by ONE of the following:</p> <p><b>1.1</b> Absence or deficiency (less than 40% of the lab specific normal mean) of acid alpha-glucosidase (GAA) activity in lymphocytes, fibroblasts or muscle</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> Molecular genetic testing for deletion or mutations in the GAA gene</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Presence of clinical signs and symptoms of the disease (e.g., cardiac hypertrophy, respiratory distress, skeletal muscle weakness, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Provider attests that the patient is not improving on their current enzyme replacement therapy (ERT) (e.g., Lumizyme, Nexviazyme) for the treatment of late-onset Pompe disease and this therapy will be stopped</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Patient weighs at least 40kg</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Opfolda will be prescribed in combination with Pombiliti (cipaglucosidase alfa-atga)</p>	

Product Name:Opfolda	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Opfolda plus Pombiliti</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Opfolda continues to be prescribed in combination with Pombiliti</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Opioid Containing Cough Preparations



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512245
<b>Guideline Name</b>	Opioid Containing Cough Preparations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name: Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuxarin ER, promethazine-codeine syrup, hydrocodone polst-chlorphen polst ER, Poly-Tussin AC, Maxi-Tuss CD, Pro-Red AC, Rydex, Ninjacof-XG, Coditussin AC, Mar-Cof CG, all guaifenesin/codeine 100-10mg/5ml products, Coditussin DAC	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 18 years of age or older</p>	

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Oral Oncology Agents



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-512246
<b>Guideline Name</b>	Oral Oncology Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/3/2026
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## 1 . Criteria

Product Name:Cyclophosphamide tablets, temozolomide caps, Tukysa, Hernexeos, Onureg, Brand Purixan susp, generic mercaptopurine susp, Jylamvo, Xatmep, Trexall, Inlyta, Fruzaqla, Lenvima, Gilotrif, Vizimpro, Brand Tarceva, generic erlotinib, Brand Iressa, generic gefitinib, Lazcluze, Tagrisso, Daurismo, Odomzo, Erivedge, Lysodren, Erleada, Brand Casodex, Nubeqa, Xtandi, nilutamide, Soltamox, Brand Fareston, Brand Arimidex, Brand Aromasin, Brand Femara, Orserdu, Orgovyx, Brand Zytiga, generic abiraterone, Abirtega, Yonsa, Akeega, Pomalyst, Venclexta, Revuforj, Ayvakit, Truqap, Alecensa, Alunbrig, Zykadia, Xalkori, Lorbrena, Verzenio, Ibrance, Kisqali, Zolanza, Romvimza, Scemblix, Bosulif, Brand Sprycel, generic dasatinib, Phyrago, Brand Gleevec, generic imatinib, Imkeldi, Nilotinib, Brand Tassigna, generic nilotinib, Danziten, Iclusig, Tafinlar, Ojemda, Zelboraf, Calquence, Imbruvica, Jaypirca, Brukinsa, Balversa, Lytgobi, Pemazyre, Ogsiveo, Krazati, Lumakras, Brand Afinitor, generic everolimus tabs, Torpenz, Brand Afinitor Disperz, generic everolimus tbso, Cabometyx, Cometriq, Xospata, Brand Tykerb, generic lapatinib, Rydapt, Nerlynx, Brand Votrient, generic pazopanib, Turalio, Vanflyta, Stivarga, Qinlock, Brand Nexavar, generic sorafenib, Brand Sutent, generic sunitinib, Fotivda, Caprelsa, Mektovi, Cotellic, Gomekli, Koselugo, Mekinist, Tazverik, Tabracta, Tepmetko, Rozlytrek, Vitrakvi, Augtyro, Ibtrozi, Tibsovo, Idhifa, Voranigo, Zejula, Lynparza, Rubraca, Talzena, Gavreto, Retevmo,

Ninlaro, Inrebic, Ojjaara, Vonjo, Jakafi, Piqray, Copiktra, Zydelig, Itovebi, Hycamtin caps, Xpovio, Modeyso, Brand Hydrea, Matulane, generic bexarotene, Iwilfin, Avmapki Fakzinja co-pack, Inqovi, Lonsurf, Thalomid, Revlimid, lenalidomide, Vijoice

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - The patient has a diagnosis that is indicated in the FDA (Food and Drug Administration) approved package insert or listed in nationally recognized compendia

**AND**

**2** - One of the following:

**2.1** The requested medication is indicated as a first line agent, either in the FDA approved package insert or nationally recognized compendia

**OR**

**2.2** The requested medication is NOT indicated as a first line agent, either in the FDA approved package insert or nationally recognized compendia, then there is documentation of previous therapies tried and failed

**AND**

**3** - The requested medication is prescribed by, or in consultation with, an oncologist or hematologist

**AND**

**4** - The patient does NOT have any contraindications to the requested medication

**AND**

**5** - The requested quantity and dosing regimen falls within the manufacturer's published dosing guidelines or nationally recognized compendia and is appropriate for the patient's age

**AND**

**6** - The requested medication will be used in combination with other chemotherapeutic or adjuvant agents according to the FDA-approved prescribing information, if applicable

**AND**

**7** - One of the following, if applicable:

**7.1** If an FDA-approved companion diagnostic test for the requested medication exists, then there is documentation that the test was performed to confirm the diagnosis

**OR**

**7.2** If a test with adequate ability to confirm a disease mutation exists, then there is documentation that the test was performed to confirm the diagnosis

**AND**

**8** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Cyclophosphamide tablets, temozolomide caps, Tukysa, Hernexeos, Onureg, Brand Purixan susp, generic mercaptopurine susp, Jylamvo, Xatmep, Trexall, Inlyta, Fruzaqla, Lenvima, Gilotrif, Vizimpro, Brand Tarceva, generic erlotinib, Brand Iressa, generic gefitinib, Lazcluze, Tagrisso, Daurismo, Odomzo, Erivedge, Lysodren, Erleada, Brand Casodex, Nubeqa, Xtandi, nilutamide, Soltamox, Brand Fareston, Brand Arimidex, Brand Aromasin, Brand Femara, Orserdu, Orgovyx, Brand Zytiga, generic abiraterone, Abirtega, Yonsa, Akeega, Pomalyst, Venclexta, Revuforj, Aывakit, Truqap, Alecensa, Alunbrig, Zykadia, Xalkori, Lorbrena, Verzenio, Ibrance, Kisqali, Zolanza, Romvimza, Scemblix, Bosulif, Brand Sprycel, generic dasatinib, Phyrago, Brand Gleevec, generic imatinib, Imkeldi, Nilotinib, Brand Tasigna, generic nilotinib, Danziten, Iclusig, Tafinlar, Ojemda, Zelboraf, Calquence, Imbruvica, Jaypirca, Brukinsa, Balversa, Lytgobi, Pemazyre, Ogsiveo, Krazati, Lumakras, Brand Afinitor, generic everolimus tabs, Torpenz, Brand Afinitor Disperz, generic everolimus

tbso, Cabometyx, Cometriq, Xospata, Brand Tykerb, generic lapatinib, Rydapt, Nerlynx, Brand Votrient, generic pazopanib, Turalio, Vanflyta, Stivarga, Qinlock, Brand Nexavar, generic sorafenib, Brand Sutent, generic sunitinib, Fotivda, Caprelsa, Mektovi, Cotellic, Gomekli, Koselugo, Mekinist, Tazverik, Tabrecta, Tepmetko, Rozlytrek, Vitrakvi, Augtyro, Ibtrozi, Tibsovo, Idhifa, Voranigo, Zejula, Lynparza, Rubraca, Talzena, Gavreto, Retevmo, Ninlaro, Inrebic, Ojjaara, Vonjo, Jakafi, Piqray, Copiktra, Zydelig, Itovebi, Hycamtin caps, Xpovio, Modeyso, Brand Hydrea, Matulane, generic bexarotene, Iwilfin, Avmapki Fakzynja co-pack, Inqovi, Lonsurf, Thalomid, Revlimid, lenalidomide, Vijoice	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of a positive clinical response to the requested treatment</p>	

## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Osphena



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442195
<b>Guideline Name</b>	Osphena
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA), due to menopause*</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:</p> <ul style="list-style-type: none"> <li>• Estradiol vaginal cream</li> <li>• Estradiol vaginal tablet</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):</p> <ul style="list-style-type: none"> <li>• Estradiol vaginal cream</li> <li>• Estradiol vaginal tablet</li> </ul>	
Notes	*Treatment of dyspareunia is a benefit exclusion.

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Osteoporosis Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-504224
<b>Guideline Name</b>	Osteoporosis Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Evenity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of postmenopausal osteoporosis or osteopenia</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p>	

**2.1 BOTH of the following:**

**2.1.1** The patient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

**AND**

**2.1.2 ONE of the following:**

- The patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm
- The patient has a documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

**OR**

**2.2 BOTH of the following:**

**2.2.1** The patient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

**AND**

**2.2.2 ONE of the following:**

**2.2.2.1** The patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

**OR**

**2.2.2.2 BOTH of the following:**

**2.2.2.2.1** The patient has a documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

**AND**

**2.2.2.2.2** ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year probabilities:

- The patient has a major osteoporotic fracture at 20% or more
- The patient has a hip fracture at 3% or more

**AND**

**3** - The patient has a documented trial and failure, contraindication, or intolerance to ONE of the following:

- Teriparatide (e.g., Forteo, Bonsity)
- Tymlos (abaloparatide)

**AND**

**4** - Treatment duration of Evenity (romosozumab-aqqg) has not exceeded a total of 12 months during the patient's lifetime

Product Name: Brand Forteo, Bonsity, Teriparatide, generic teriparatide	
Approval Length	24 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - For Postmenopausal Osteoporosis or Osteopenia, or Men with Primary or Hypogonadal Osteoporosis or Osteopenia at High Risk for Fracture, BOTH of the following:</p> <p><b>1.1</b> ONE of the following:</p> <p><b>1.1.1</b> BOTH of the following:</p> <p><b>1.1.1.1</b> The patient has a BMD T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)</p> <p style="text-align: center;"><b>AND</b></p>	

**1.1.1.2 ONE of the following:**

- The patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm
- Documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

**OR**

**1.1.2 BOTH of the following:**

**1.1.2.1** The patient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

**AND**

**1.1.2.2 ONE of the following:**

**1.1.2.2.1** Patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

**OR**

**1.1.2.2.2 BOTH of the following:**

**1.1.2.2.2.1** Patient has a documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

**AND**

**1.1.2.2.2.2 ONE of the following FRAX 10-year probabilities:**

- Major osteoporotic fracture at 20% or more
- Hip fracture at 3% or more

**AND**

**1.2** Patient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime

**OR**

**2** - For Glucocorticoid-Induced Osteoporosis at High Risk for Fracture, ALL of the following:

**2.1** The patient has a documented history of prednisone or its equivalent at a dose at least 5 mg/day for at least 3 months

**AND**

**2.2** ONE of the following:

**2.2.1** BMD T-score of -2.5 or lower based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site)

**OR**

**2.2.2** The patient has one of the following FRAX 10-year probabilities:

- Major osteoporotic fracture at 20% or more
- Hip fracture at 3% or more

**OR**

**2.2.3** The patient has a documented history of one of the following fractures resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

**AND**

**2.3** Documented trial and failure, contraindication, or intolerance to ONE bisphosphonate (e.g., alendronate)

**AND**

**2.4** The patient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime

Product Name:Tymlos	
Approval Length	24 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of osteoporosis or osteopenia</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Postmenopausal female at high risk for fracture or has failed or is intolerant to other available osteoporosis therapy</li> <li>• Male at high risk for fracture or has failed or is intolerant to other available osteoporosis therapy</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - ONE of the following:</p> <p><b>3.1</b> BOTH of the following:</p> <p><b>3.1.1</b> BMD T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)</p>	

**AND**

**3.1.2** ONE of the following:

- Documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm
- Documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

**OR**

**3.2** BOTH of the following:

**3.2.1** Patient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

**AND**

**3.2.2** ONE of the following:

**3.2.2.1** Patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

**OR**

**3.2.2.2** BOTH of the following:

**3.2.2.2.1** Documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

**AND**

**3.2.2.2.2** The patient has ONE of the following FRAX 10-year probabilities:

- Major osteoporotic fracture at 20% or more
- Hip fracture at 3% or more

**AND**

**4** - Patient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during their lifetime

## **2 . Revision History**

Date	Notes
1/21/2026	New program

Oxervate



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-423406
<b>Guideline Name</b>	Oxervate
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Oxervate	
Approval Length	8 Week(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 2 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Diagnosis of moderate to severe (stage two or stage three) neurotrophic keratitis (NK)</p>	

**AND**

**3** - Prescribed by or in consultation with an ophthalmologist

**AND**

**4** - Prescriber attestation that patient or caregiver has been counseled on proper administration technique

**AND**

**5** - Patient has not exceeded eight kits per affected eye per lifetime

## 2 . Revision History

Date	Notes
10/22/2025	New

Palforzia



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442196
<b>Guideline Name</b>	Palforzia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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## 1 . Criteria

Product Name:Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis and clinical history of peanut allergy as documented by BOTH of the following:

- A serum peanut-specific IgE (immunoglobulin E) level of greater than or equal to 0.35 kUA/L (kilounits of allergen/liter)
- A mean wheal diameter that is at least 3 mm (millimeters) larger than the negative control on skin-prick testing for peanut

**AND**

**2** - ONE of the following:

**2.1** BOTH of the following:

- Patient is 1 to 17 years of age
- Patient is in the initial dose escalation phase of therapy

**OR**

**2.2** BOTH of the following:

- Patient is 1 year of age and older
- Patient is in the up-dosing or maintenance phase of therapy

**AND**

**3** - Used in conjunction with a peanut-avoidant diet

**AND**

**4** - Patient does not have any of the following:

- History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease
- History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months

<ul style="list-style-type: none"> <li>• Severe or poorly controlled asthma</li> </ul>
<b>AND</b>
<b>5</b> - Prescribed by or in consultation with an allergist/immunologist
<b>AND</b>
<b>6</b> - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Palforzia therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Used in conjunction with a peanut-avoidant diet</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by or in consultation with an allergist/immunologist</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Palsonify



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-521212
<b>Guideline Name</b>	Palsonify
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> </ul>

**Guideline Note:**

Effective Date:	3/1/2026
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**1 . Criteria**

Product Name: Palsonify	
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of acromegaly</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is greater than or equal to 18 years old</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• Patient had an inadequate response to surgery</li> <li>• Patient is not a candidate for surgery</li> </ul>	

Product Name:Palsonify	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Palsonify therapy</p>	

**2 . Revision History**

Date	Notes
2/12/2026	New Program.



Palynziq



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-501215
<b>Guideline Name</b>	Palynziq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

#### Guideline Note:

Effective Date:	2/1/2026
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#### 1 . Criteria

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
	<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of phenylketonuria (PKU)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Patient is actively on a phenylalanine-restricted diet</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - ONE of the following:</b></p> <p><b>3.1 Failure to sapropterin as confirmed by claims history or submission of medical records</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance)</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>3.3 Patient is not an appropriate candidate for sapropterin due to two null mutations in trans</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Physician attestation that the patient will not be receiving Palynziq in combination with sapropterin dihydrochloride or Sepiience (sepiapterin)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>5 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration greater than 600 micromoles/liter</b></p>

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient is actively on a phenylalanine-restricted diet</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - ONE of the following:</p> <p><b>2.1</b> Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration less than 600 micromoles/liter</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has achieved a 20% reduction in blood phenylalanine concentration from pre-treatment baseline</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.3</b> Patient is in initial titration/maintenance phase of dosing regimen and dose is being titrated based on blood phenylalanine concentration response up to maximum labeled dosage of 60 milligrams once daily</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Palynziq in combination with sapropterin dihydrochloride or Sepience (sepiapterin) [Prescription claim history that does not show any concomitant sapropterin dihydrochloride or Sepience (sepiapterin) claim within 60 days of reauthorization request may be used as documentation]</p>	

## 2 . Revision History

Date	Notes
1/15/2026	Removed PACAID. Added Sephience to combination use criteria. Updated initial auth to remove specified length of sapropterin therapy trial requirement and to exclude patients with two null mutations in trans.

Penicillamine



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422568
<b>Guideline Name</b>	Penicillamine
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Wilson’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Wilson’s Disease</p>	

**AND**

**2** - Prescribed by or in consultation with a gastroenterologist, hepatologist, rheumatologist, or liver transplant physician

Product Name: Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Wilson's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Documentation of positive clinical response to therapy</p>	

Product Name: Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Cystinuria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of cystinuria</p>	

<b>AND</b>
<b>2</b> - Patient has a history of failure, contraindication, or intolerance to conservative treatment measures (e.g., use of urinary alkalization such as potassium citrate, high fluid intake, sodium, and protein restriction)
<b>AND</b>
<b>3</b> - Prescribed by or in consultation with a nephrologist or urologist

Product Name: Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Cystinuria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of cystinuria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by or in consultation with a nephrologist or urologist</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Documentation of positive clinical response to therapy</p>	

Product Name: Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Rheumatoid arthritis (RA)
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of severe active rheumatoid arthritis (RA)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of at least one non-biologic DMARD (e.g., methotrexate, leflunomide, azathioprine)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by or in consultation with a rheumatologist</p>	

Product Name: Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Rheumatoid arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of severe active rheumatoid arthritis (RA)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by or in consultation with a rheumatologist</p>	

**AND**

**3** - Documentation of positive clinical response to therapy

## **2 . Revision History**

Date	Notes
10/23/2025	New program

Phexxi



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442198
<b>Guideline Name</b>	Phexxi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Phexxi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Used for the prevention of pregnancy

**AND**

2 - ONE of the following:

**2.1** Failure to ALL of the following methods of contraception as confirmed by claims history or submission of medical records:

- Injection (e.g., Depo-Provera)
- Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz]
- Transdermal Patch (e.g., Twirla, Xulane)
- Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing)
- Diaphragm
- Cervical Cap (e.g., FemCap)
- Female Condom

**OR**

**2.2** History of intolerance or contraindication to ALL of the following methods of contraception (please document intolerance or contraindication):

- Injection (e.g., Depo-Provera)
- Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz]
- Transdermal Patch (e.g., Twirla, Xulane)
- Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing)
- Diaphragm
- Cervical Cap (e.g., FemCap)
- Female Condom

**AND**

3 - ONE of the following:

**3.1** Failure to nonoxynol-9 based spermicide as confirmed by claims history or submission of medical records

**OR**

**3.2** History of intolerance or contraindication to nonoxynol-9 based spermicide (please document intolerance or contraindication)

**AND**

**4** - Provider attests they have counseled the patient regarding higher rate of pregnancy prevention with the use of other methods of contraception (e.g., injection, oral contraception, transdermal patch, vaginal ring) compared to Phexxi

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Platelet Inhibitors



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512247
<b>Guideline Name</b>	Platelet Inhibitors
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name:Brand Brilinta, generic ticagrelor	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Acute Coronary Syndrome (ACS) (i.e., unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient does not have an active pathological bleed or history of intracranial hemorrhage

**AND**

**3** - The patient will be receiving concomitant treatment with aspirin dosed less than 100 mg/daily

**AND**

**4** - ONE of the following:

- The patient has been started and stabilized on the requested medication
- The patient has experienced an adverse event with or has an allergy or contraindication to clopidogrel
- Another clinically appropriate rationale is provided for why clopidogrel cannot be used (document rationale)

**AND**

**5** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Brand Effient, generic prasugrel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of Acute Coronary Syndrome (ACS) (i.e., unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient does not have an active pathological bleed or history of transient ischemic attack or cerebral vascular accident (CVA)

**AND**

**3** - The patient will be receiving concomitant treatment with aspirin dosed less than 100 mg/daily

**AND**

**4** - The patient has a history of percutaneous coronary intervention

**AND**

**5** - ONE of the following:

- The patient has been started and stabilized on the requested medication
- The patient has experienced an adverse event with or has an allergy or contraindication to clopidogrel
- Another clinically appropriate rationale is provided for why clopidogrel cannot be used (document rationale)

**AND**

**6** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Polyneuropathy of Hereditary Amyloidosis Agents



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-395190
<b>Guideline Name</b>	Polyneuropathy of Hereditary Amyloidosis Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Onpattro	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis confirmed by testing (e.g., genetic testing, biopsy)

**AND**

**3** - Prescribed by, or in consultation with, a cardiologist, geneticist, neurologist, or other specialist with advanced knowledge in treating hereditary transthyretin mediated amyloidosis

**AND**

**4** - The patient has clinical manifestations of polyneuropathy

**AND**

**5** - Onpattro will not be used in combination with other transthyretin (TTR) reducing or stabilizing agents (e.g., eplontersen, inotersen, tafamidis, vutrisiran, etc.)

**AND**

**6** - The patient does not have any of the following conditions:

- Severe renal impairment or end-stage renal disease
- Moderate or severe hepatic impairment
- Prior liver transplant

**AND**

**7** - Prescriber will supplement vitamin A at the recommended daily allowance as appropriate and refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness, dry eyes) occur

**AND**

**8** - Onpattro will be dosed every three weeks per FDA-label based on patient actual body weight

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name: Onpattro	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient has demonstrated a clinical benefit based on improvement in clinical manifestations of polyneuropathy from baseline</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The patient has not experienced any treatment restricting adverse effects (e.g., severe ocular symptoms related to vitamin A deficiency)</p>	

**2 . Revision History**

Date	Notes
9/10/2025	1/1/2026 Implementation

Preferred Non-Solid Dosage Forms



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512248
<b>Guideline Name</b>	Preferred Non-Solid Dosage Forms
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHI EC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State North Carolina (ACUNC)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Diagnosis	Requests for Non-Solid Dosage Forms
Approval Length	12 month(s)
Guideline Type	Administrative

**Approval Criteria**

**1** - ONE of the following:

**1.1** Requested drug must be used for an FDA (Food and Drug Administration)-approved indication

**OR**

**1.2** The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopeia-National Formulary (USP-NF)

**AND**

**2** - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

**AND**

**3** - ONE of the following:

**3.1** BOTH of the following:

**3.1.1** The patient is able to swallow a solid dosage form

**AND**

**3.1.2** ONE of the following:

**3.1.2.1** History of failure to at least THREE preferred\* solid oral dosage forms as confirmed by claims history or submission of medical records. NOTE: In instances where there are fewer

than three preferred alternatives, the patient must have a history of failure to ALL of the preferred products.

**OR**

**3.1.2.2** History of contraindication or intolerance to THREE preferred\* solid oral dosage forms (please specify contraindication or intolerance). NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to ALL of the preferred products.

**OR**

**3.1.2.3** There are no preferred formulary alternatives for the requested drug

**OR**

**3.2** Patient is unable to swallow a solid dosage form

**OR**

**3.3** Patient utilizes a feeding tube for medication administration

**OR**

**3.4** Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation

Notes

\*See Table 1 in Background for PDL links. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.

## 2 . Background

<b>Benefit/Coverage/Program Information</b>	
<b>Table 1. PDL Links</b>	
<b>Arizona</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP">https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP</a>
<b>Colorado</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html</a>
<b>Hawaii</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html</a>
<b>Indiana</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html</a>
<b>Maryland</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html</a>
<b>Michigan</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/michigan-health-plans/mi-comm-plan-home/mi-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/michigan-health-plans/mi-comm-plan-home/mi-cp-pharmacy.html</a>
<b>New Jersey</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html</a>
<b>New Mexico</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html</a>
<b>North Carolina</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home/nc-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home/nc-cp-pharmacy.html</a>
<b>Pennsylvania CAID/CHIP</b>	<a href="https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP">https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP</a>
<b>Nevada</b>	<a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

### 3 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Pretomanid



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442201
<b>Guideline Name</b>	Pretomanid
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Pretomanid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - One of the following:

1.1 Diagnosis of pulmonary extensively drug resistant (XDR) tuberculosis (TB)

**OR**

1.2 Treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)

**AND**

2 - Pretomanid will be used in combination with bedaquiline and linezolid

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Prevymis



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-435235
<b>Guideline Name</b>	Prevymis
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Prevymis tabs	
Diagnosis	Cytomegalovirus Prophylaxis
Approval Length	9 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - ALL of the following:</b></p> <p><b>1.1</b> Patient is a recipient of an allogeneic hematopoietic stem cell transplant</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2</b> Patient is cytomegalovirus (CMV)-seropositive</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.3</b> Provider attests to both of the following:</p> <ul style="list-style-type: none"><li>• Prevymsis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment)</li><li>• Prevymsis is being prescribed as prophylaxis and not treatment of CMV infection</li></ul> <p style="text-align: center;"><b>OR</b></p> <p><b>2 - ALL of the following:</b></p> <p><b>2.1</b> Patient is a recipient of a kidney transplant</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2.2</b> Patient is CMV-seronegative</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2.3</b> Donor is CMV-seropositive</p>	

**AND**

**2.4** Provider attests to both of the following:

- Prevyomis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment)
- Prevyomis is being prescribed as prophylaxis and not treatment of CMV infection

## **2 . Revision History**

Date	Notes
11/3/2025	Updated formatting of attestations. Combined VA, NE, NM formularies. Added NV formulary.

Primary Hyperoxaluria Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-475235
<b>Guideline Name</b>	Primary Hyperoxaluria Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Oxlumo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by ONE of the following:</p> <ul style="list-style-type: none"> <li>Biallelic pathogenic mutation in the alanine: glyoxylate aminotransferase (AGXT) gene as identified on molecular genetic testing</li> </ul>	

- Identification of alanine: glyoxylate aminotransferase (AGT) enzyme deficiency on liver biopsy

**AND**

**2** - Oxlumo will be used to lower urinary oxalate levels

**AND**

**3** - Prescribed by, or in consultation with, a nephrologist, urologist, or geneticist

**AND**

**4** - The patient has not had a liver transplant

**AND**

**5** - Oxlumo will not be used in combination with other urinary oxalate reducing agents (e.g. Rivfloza)

**AND**

**6** - The patient has a baseline assessment for at least ONE of the following:

- Urinary oxalate excretion level (corrected for BSA)
- Spot urinary oxalate: creatinine ratio
- eGFR
- Plasma oxalate level

**AND**

**7** - Oxalate will be dosed per FDA label based on patient's weight.

Product Name: Rivfloza	
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 9 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The patient has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Biallelic pathogenic mutation in the AGXT gene as identified on molecular genetic testing</li> <li>• Identification of AGT enzyme deficiency on liver biopsy</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - Rivfloza will be used to lower urinary oxalate levels</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by, or in consultation with, a nephrologist, urologist, or geneticist</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - The patient does not have renal impairment defined as an eGFR less than 30 mL/min/1.73 m<sup>2</sup></p> <p style="text-align: center;"><b>AND</b></p> <p>6 - The patient has not had a liver transplant</p>	

**AND**

**7** - Rivfloza will not be used in combination with other urinary oxalate reducing agents (e.g., Oxlummo)

**AND**

**8** - The patient has a baseline assessment for at least ONE of the following:

- Urinary oxalate excretion level (corrected for BSA)
- Spot urinary oxalate: creatinine ratio
- eGFR
- Plasma oxalate level

**AND**

**9** - Rivloza will be dosed per FDA label based on the patient's weight

Product Name:Oxlumo, Rivfloza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient has ONE of the following disease responses:</p> <ul style="list-style-type: none"> <li>• Decrease in urinary oxalate excretion level (corrected for BSA) from baseline</li> <li>• Reduction in spot urinary oxalate: creatinine ratio from baseline</li> <li>• Stabilization of eGFR</li> </ul>	

- Decrease in plasma oxalate level from baseline

## 2 . Revision History

Date	Notes
12/11/2025	Updated therapy stage of first criteria box for Oxlumo from Reauthorization to Initial Authorization.

Procysbi



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442202
<b>Guideline Name</b>	Procysbi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Procysbi	
Approval Length	12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of nephropathic cystinosis</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 1 year of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following*:</p> <p>3.1 Failure to Cystagon as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p>3.2 History of intolerance or contraindication to Cystagon (please specify intolerance or contraindication)</p>	
Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity.

Product Name: Procysbi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Procysbi therapy</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Progesterone - Non-Oral



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442203
<b>Guideline Name</b>	Progesterone - Non-Oral
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Crinone, Endometrin	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Progesterone - Oral



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442204
<b>Guideline Name</b>	Progesterone - Oral
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Prometrium, generic progesterone caps	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of ONE of the following:

- Amenorrhea
- Endometrial hyperplasia or prevention of endometrial hyperplasia
- Abnormal uterine or vaginal bleeding
- History of preterm birth
- Prevention of preterm delivery for current pregnancy

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Promacta, Alvaiz



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-485189
<b>Guideline Name</b>	Promacta, Alvaiz
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic idiopathic thrombocytopenic purpura (ITP)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records:</p> <ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Immunoglobulins</li> <li>• Splenectomy</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):</p> <ul style="list-style-type: none"> <li>• Corticosteroids</li> <li>• Immunoglobulins</li> <li>• Splenectomy</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - If the request is for Alvaiz, ONE of the following:</p> <p>3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p>3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)</p>	

**AND**

**4** - If the request is for Promacta powder for oral suspension, ONE of the following:

**4.1** Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- oral/motor difficulties
- dysphagia

**OR**

**4.2** Patient utilizes a feeding tube for medication administration

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy	

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of chronic hepatitis C-associated thrombocytopenia

**AND**

2 - ONE of the following:

- Planning to initiate and maintain interferon-based treatment
- Currently receiving interferon-based treatment

**AND**

3 - If the request is for Alvaiz, ONE of the following:

3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

**OR**

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

**AND**

4 - If the request is for Promacta powder for oral suspension, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- oral/motor difficulties
- dysphagia

**OR**

4.2 Patient utilizes a feeding tube for medication administration

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C</p>	

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of severe aplastic anemia</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p><b>2.1</b> Used in combination with standard immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]</p> <p style="text-align: center;"><b>OR</b></p>	

**2.2** History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

**AND**

**3** - If the request is for Alvaiz, ONE of the following:

**3.1** Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

**AND**

**4** - If the request is for Promacta powder for oral suspension, ONE of the following:

**4.1** Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- oral/motor difficulties
- dysphagia

**OR**

**4.2** Patient utilizes a feeding tube for medication administration

Product Name: Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy

Product Name: Brand Promacta, generic eltrombopag, Alvaiz

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Promacta, generic eltrombopag, Alvaiz

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to therapy

**2 . Revision History**

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

12/18/2025	Removed IN from formularies - see state specific GL-475187 for IN 1 .1.26. No other changes to guideline.
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Proton Pump Inhibitors (PPIs)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-404254
<b>Guideline Name</b>	Proton Pump Inhibitors (PPIs)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: All RX and OTC products of the following: omeprazole, Prilosec, pantoprazole, Protonix, rabeprazole, Aciphex, dexlansoprazole, Dexilant, esomeprazole, Nexium, lansoprazole, Prevacid	
Diagnosis	Requests exceeding once daily dosing
Approval Length	12 month(s)
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - The patient has failed an appropriate duration of once daily dosing</p>	

**OR**

**2** - The patient has a diagnosis of a hypersecretory condition (e.g., Zollinger-Ellison Syndrome), esophagitis, Barrett’s esophagitis, reflux esophagitis, or treatment of an ulcer caused by H. Pylori

Product Name: All RX and OTC products of the following: omeprazole, Prilosec, pantoprazole, Protonix, rabeprazole, Aciphex, dexlansoprazole, Dexilant, esomeprazole, Nexium, lansoprazole, Prevacid

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

**2 . Revision History**

Date	Notes
10/2/2025	Added NP check

Psychotropic Polypharmacy for Patients Under 18 years of age



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-522192
<b>Guideline Name</b>	Psychotropic Polypharmacy for Patients Under 18 years of age
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/11/2026
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## 1 . Criteria

Product Name: Brand Lunesta, generic eszopiclone, zaleplon, Zolpidem, Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem CR, zolpidem SL, Edluar, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin (sleep) 3mg and 6 mg tabs, Belsomra, Dayvigo, Quviviq, Brand Precedex, generic dexmedetomidine, Igalmi, Brand Hetlioz, generic tasimelteon, Hetlioz LQ, Brand Restoril, generic temazepam, Brand Halcion, generic triazolam, Brand Doral, generic quazepam, flurazepam, estazolam, Abilify Maintena, Opipza, Aristada, Abilify Asimtufii, aripiprazole oral soln, Brand Abilify, generic aripiprazole tab, aripiprazole ODT, Abilify Mycite, Secuado, Brand Saphris, generic asenapine, Rexulti, Vraylar, chlorpromazine, fluphenazine, haloperidol, Fanapt, Adasuve, loxapine, Caplyta, Brand Latuda, generic lurasidone, molindone, Brand Zyprexa, generic olanzapine, Brand Zyprexa Zydis, generic olanzapine ODT, Zyprexa Relprevv, Brand Symbyax, generic olanzapine/fluoxetine, Lybalvi, Brand Invega, generic paliperidone, Invega Sustenna, Erzofri, Invega Trinza, Invega Hafyera, perphenazine, perphenazine/amitriptyline, Nuplazid, pimozide, Brand Seroquel, generic quetiapine, Brand Seroquel XR, generic quetiapine ER, Perseris, Uzedy, Rykindo, Brand Risperdal, generic risperidone, risperidone ODT, generic risperidone IM, thioridazine, trifluoperazine, Cobenfy, Brand Geodon caps, generic ziprasidone caps, amitriptyline, amoxapine, chlordiazepoxide/amitriptyline, Brand Celexa, generic citalopram,

Brand Anafranil, generic clomipramine, Brand Norpramin, generic desipramine, Desvenlafaxine, Brand Pristiq, generic desvenlafaxine, doxepin caps/conc, Drizalma, duloxetine, Escitalopram, Brand Lexapro, generic escitalopram, Exxua, Brand Prozac, generic fluoxetine, fluvoxamine, imipramine, Marplan, Fetzima, Savella, Brand Pamelor, generic nortriptyline, Brand Paxil, generic paroxetine, Brand Paxil CR, generic paroxetine ER, Brand Nardil, generic phenelzine, protriptyline, Emsam, Brand Zoloft, generic sertraline, Duloxicaine, Brand Parnate, generic tranlycypromine, trimipramine, Venlafaxine, generic venlafaxine, Brand Effexor XR, generic venlafaxine ER, Qelbree, Zurzuvae, Eptol, Brand Tegretol, generic carbamazepine, Brand Tegretol XR, generic carbamazepine ER, Brand Tegretol, generic carbamazepine, Brand Carbatrol, Brand Tegretol XR, generic carbamazepine, generic carbamazepine ER, Equetro, Brand Depakote, generic divalproex, Brand Depakote ER, generic divalproex ER, Brand Lamictal, Subvenite, generic lamotrigine, Brand Lamictal ODT, generic lamotrigine ODT, Brand Lamictal XR, generic lamotrigine ER, lithium, Brand Lithobid, generic lithium ER, Brand Trileptal, generic oxcarbazepine, Brand Oxtellar XR, generic oxcarbazepine ER, valproic acid, Brand Xanax, generic alprazolam, alprazolam ODT, Brand Xanax XR, generic alprazolam ER, chlordiazepoxide, Brand Klonopin, generic clonazepam, clonazepam ODT, clorazepate, Diazepam, Brand Valium, generic diazepam, Loreev XR, Brand Ativan, generic lorazepam, oxazepam

Diagnosis	DUR: Therapeutic Duplication
Approval Length	*If the requested medication is being cross tapered, approval length is 30 days; otherwise, approval length is 12 months
Guideline Type	Administrative

**Approval Criteria**

1 - Both of the following:

- The request is for an antidepressant, antipsychotic, anticonvulsant, or mood stabilizer
- The requested medication is prescribed by a board-certified child psychiatrist

**OR**

2 - All of the following:

2.1 One of the following:

2.1.1 The requested medication(s) will be used for cross tapering and situations where the patient will be discontinuing the previously prescribed medication\*

**OR**

**2.1.2** Both of the following:

- The requested medication is being given to augment the effect of another psychotropic medication
- Each medication is supported by individual authorizations

**AND**

**2.2** The patient has a trial of each individual medication alone (please document the reasons for an inadequate response)

**AND**

**2.3** All psychotropic medications included in the must be utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

## 2 . Revision History

Date	Notes
2/11/2026	Added Qelbree

Pulmonary Arterial Hypertension Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512251
<b>Guideline Name</b>	Pulmonary Arterial Hypertension Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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### 1 . Criteria

Product Name: Tyvaso, Tyvaso DPI, Orenitram, brand Tracleer, generic bosentan, Adempas, Brand Letairis, generic ambrisentan, Opsumit, Uptravi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of one of the following:</p> <ul style="list-style-type: none"> <li>Pulmonary Arterial Hypertension</li> <li>Pulmonary Hypertension, Unspecified</li> <li>Secondary Pulmonary Arterial Hypertension</li> <li>Pulmonary Hypertension Due to Left Heart Disease</li> </ul>	

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<ul style="list-style-type: none"> <li>• Pulmonary Hypertension Due to Lung Diseases and Hypoxia</li> <li>• Pulmonary Heart Disease, Unspecified</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca), Brand Revatio, generic sildenafil 20 mg, generic sildenafil susp, Opsynvi, Tadliq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of one of the following:</p> <ul style="list-style-type: none"> <li>• Pulmonary Arterial Hypertension</li> <li>• Pulmonary Hypertension, Unspecified</li> <li>• Secondary Pulmonary Arterial Hypertension</li> <li>• Pulmonary Hypertension Due to Left Heart Disease</li> <li>• Pulmonary Hypertension Due to Lung Diseases and Hypoxia</li> <li>• Pulmonary Heart Disease, Unspecified</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Medication is NOT being prescribed for impotence or erectile dysfunction</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Pulmozyme



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442206
<b>Guideline Name</b>	Pulmozyme
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Pulmozyme	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of cystic fibrosis</p>	

## 2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Pyrukynd (mitapivat)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-382198
<b>Guideline Name</b>	Pyrukynd (mitapivat)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is greater than or equal to 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of pyruvate kinase deficiency (PDK) defined by documented presence of at least two variant alleles in the PKLR gene, of which at least one was a missense variant

**AND**

**3** - Patient is not homozygous for the c.1436G>A (p.R470H) variant

**AND**

**4** - Patient does not have two non-missense variants (without the presence of another missense variant) in the PKLR gene

**AND**

**5** - One of the following:

- Patient has a baseline serum hemoglobin level less than 10 g/dL
- Patient required more than six transfusions in the prior year

**AND**

**6** - Other causes of hemolytic anemia have been ruled out (e.g., immune hemolysis, other enzyme deficiencies, vitamin/mineral deficiencies)

**AND**

**7** - Patient does not have moderate or severe hepatic impairment

**AND**

**8** - Prescriber will advise patients currently on hormonal contraceptives to use an alternative non-hormonal contraceptive method or add a barrier method of contraception during treatment

**AND**

**9** - The request does not exceed 60 tablets/30 days (max dose 100 mg/day)

Product Name: Pyrukynd Taper Pack, Pyrukynd	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient has shown a beneficial response to therapy compared to pre-treatment baseline in <b>ONE</b> of the following:</p> <p><b>2.1</b> Hemoglobin (Hb) response (defined as a greater than or equal to 1.5 g/dL increase in Hb level without transfusion over a four week or longer time period)</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> Transfusion reduction response (defined as a greater than or equal to 33% reduction in the number of red blood cell [RBC] units transfused compared to historical transfusion burden)</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.3</b> Patient had an increase in Hb and/or decrease in transfusion requirement, to a lesser extent than the above, and also had an improvement in the signs and symptoms (e.g., fatigue, jaundice, shortness of breath) and/or markers of hemolysis (e.g., indirect bilirubin, reticulocyte count, lactate dehydrogenase [LDH], haptoglobin)</p>	

## 2 . Revision History

Date	Notes
9/4/2025	New GL. 1/1/2026 Implementation

Qalsody



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-431189
<b>Guideline Name</b>	Qalsody
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Qalsody	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Amyotrophic Lateral Sclerosis (ALS) based on validated criteria (e.g., revised El Escorial criteria, Awaji criteria, Gold Coast criteria)</p>	

<b>AND</b>
<b>2</b> - The patient is 18 years of age or older
<b>AND</b>
<b>3</b> - The patient has a baseline measure of plasma neurofilament light chain (NfL)
<b>AND</b>
<b>4</b> - Prescribed by or in consultation with a neurologist
<b>AND</b>
<b>5</b> - The patient has the presence of a superoxide dismutase 1 (SOD1) gene mutation
<b>AND</b>
<b>6</b> - Dosing is in accordance with FDA approved labeling

<b>Product Name: Qalsody</b>	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Prescribed by or in consultation with a neurologist</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient must have stabilization or improvement in plasma NfL compared to baseline

**AND**

**3** - The patient has responded to therapy compared to pretreatment baseline with disease stability or mild progression (patient has not experienced rapid disease progression while on therapy)

**AND**

**4** - Dosing is in accordance with FDA approved labeling

## **2 . Revision History**

Date	Notes
10/23/2025	New program

Quantity Limits



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-442207
<b>Guideline Name</b>	Quantity Limits
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review (General)
Approval Length	12 month(s)
Guideline Type	Administrative

**Approval Criteria**

**1 - ONE of the following:**

**1.1** The requested drug must be used for an FDA (Food and Drug Administration)-approved indication

**OR**

**1.2** The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

**AND**

**2 - ONE of the following:**

**2.1** The drug is being prescribed within the manufacturer's published dosing guidelines

**OR**

**2.2** The request falls within dosing guidelines found in ONE of the following compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

**AND**

**3** - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation.

**AND**

**4** - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program.

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review for the treatment of gender dysphoria*
Approval Length	12 month(s)
Guideline Type	Administrative
<p><b>Approval Criteria</b></p> <p><b>1</b> - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:</p> <ul style="list-style-type: none"> <li>• American Hospital Formulary Service Drug Information</li> <li>• National Comprehensive Cancer Network Drugs and Biologics Compendium</li> <li>• Thomson Micromedex DrugDex</li> <li>• Clinical pharmacology</li> <li>• United States Pharmacopoeia-National Formulary (USP-NF)</li> </ul> <p><b>AND</b></p> <p><b>2</b> - The drug is being prescribed for an indication that is recognized as a covered benefit by the applicable health plans' program.</p>	
Notes	* If the above criteria are not met, then refer for clinical review by an appropriate trained professional (physician or pharmacist) based on the applicable regulatory requirement.

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Monthly prescription limit review for migraine therapy, benzodiazepines, or muscle relaxants

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Approval Length	1 month(s)
Guideline Type	Administrative
<p><b>Approval Criteria</b></p> <p>1 - Medical necessity rationale provided for why the member requires 5 or more fills of the same drug or drug class within a month.</p>	
Notes	*If deemed medically necessary, longer authorization duration is permitted

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Topical products exceeding the allowable package size per fill OR the allowable quantity per month
Approval Length	12 month(s)
Guideline Type	Administrative
<p><b>Approval Criteria</b></p> <p>1 - The physician attests that a larger quantity is needed for treatment of a larger surface area.</p>	

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Qutenza (capsaicin)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422548
<b>Guideline Name</b>	Qutenza (capsaicin)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Qutenza	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of ONE of the following:

- Neuropathic pain associated with postherpetic neuralgia
- Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet

<b>AND</b>
<b>2</b> - History of failure or intolerance to over-the-counter capsaicin

Product Name: Qutenza	
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - At least three months have transpired since the last Qutenza application/administration</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient experienced pain relief with a prior course of therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient is experiencing a return of neuropathic pain</p>	

**2 . Revision History**

Date	Notes
10/22/2025	New program

Radicava ORS



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442209
<b>Guideline Name</b>	Radicava ORS
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Radicava ORS	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - BOTH of the following:</p> <p>1.1 Patient has been established on therapy with edaravone for amyotrophic lateral sclerosis (ALS) under an active UnitedHealthcare medical benefit prior authorization</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 ALL of the following:</p> <p>1.2.1 Diagnosis of ALS</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.3 Patient is currently receiving edaravone therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.4 Patient is not dependent on invasive ventilation</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - ALL of the following:</p> <p>2.1 Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of ALS</p>	

**AND**

**2.2** Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

**AND**

**2.3** Submission of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score confirming that the patient has scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment

**AND**

**2.4** Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

Product Name:Radicava ORS

Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Diagnosis of amyotrophic lateral sclerosis (ALS)

**AND**

**2** - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

**AND**

**3** - Patient is currently receiving Radicava ORS therapy

**AND**

**4** - Patient is not dependent on invasive ventilation

## **2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Ravicti



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-442210
<b>Guideline Name</b>	Ravicti
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Ravicti	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of urea cycle disorders (UCDs)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient does not have N-acetylglutamate synthase (NAGS) deficiency</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Inadequate response to ONE of the following:</p> <ul style="list-style-type: none"> <li>• Dietary protein restriction</li> <li>• Amino acid supplementation</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - ONE of the following:</p> <p><b>5.1</b> BOTH of the following:</p> <p><b>5.1.1</b> Failure to sodium phenylbutyrate (Buphenyl) as confirmed by claims history or submission of medical records*</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5.1.2</b> Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following while on sodium phenylbutyrate</p>	

<ul style="list-style-type: none"> <li>• Fasting ammonia level greater than 0.5 ULN</li> <li>• Any ammonia level (fasting/non-fasting) above the ULN</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>5.2</b> History of intolerance or contraindication to sodium phenylbutyrate (Buphenyl) (please specify contraindication or intolerance)*</p> <p style="text-align: center;"><b>OR</b></p> <p><b>5.3</b> Patient is currently on Ravicti therapy</p>	
Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens an indication of medical necessity

Product Name:Ravicti	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Ravicti therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is actively on dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)</p>	

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary



Rayaldee (calcifediol)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-390215
<b>Guideline Name</b>	Rayaldee (calcifediol)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Rayaldee	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is greater than or equal to 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has a diagnosis of secondary hyperparathyroidism (HPT)

**AND**

**3** - Patient has BOTH of the following:

**3.1** Serum total 25-hydroxyvitamin D level less than 30 ng/mL (nanograms/milliliter)

**AND**

**3.2** Serum corrected total calcium below 9.8 mg/dL (milligrams/deciliter)

**AND**

**4** - Patient has chronic kidney disease (CKD) Stage 3 or 4

**AND**

**5** - Patient does NOT have CKD Stage 5 or end stage renal disease (ESRD) on dialysis

**AND**

**6** - Patient has a history of failure, contraindication, or intolerance to an adequate trial of ALL of the following:

- Calcitriol
- Doxercalciferol
- Paricalcitol

**AND**

**7** - Prescribed by or in consultation with a nephrologist or endocrinologist

Product Name:Rayaldee

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has demonstrated positive response to treatment as defined by increase in serum total 25-hydroxyvitamin D level and/or decrease in intact parathyroid hormone (iPTH)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by or in consultation with a nephrologist or endocrinologist</p>	

## 2 . Revision History

Date	Notes
9/10/2025	New program.

Rayos (prednisone delayed release), Eohilia (budesonide oral suspension)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-458406
<b>Guideline Name</b>	Rayos (prednisone delayed release), Eohilia (budesonide oral suspension)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Rayos	
Approval Length	Initial authorization length is 3 months; Reauthorization length is 12 months
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The requested medication is being used for an FDA (Food and Drug Administration) approved indication</p>	

**AND**

**2** - Documentation of an inadequate response or adverse reaction to generic prednisone immediate-release tablets

Product Name:Eohilia	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient is 11 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has a documented diagnosis of Eosinophilic Esophagitis (EoE)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient has experienced an inadequate response to at least an 8-week trial of proton pump inhibitor (PPI), unless contraindicated or not tolerated</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Both of the following:</p> <ul style="list-style-type: none"> <li>• The requested medication is being dosed per FDA-(Food and Drug Administration) label</li> <li>• The patient has not exceeded a maximum 12-week course</li> </ul> <p style="text-align: center;"><b>AND</b></p>	

**5** - The requested medication is prescribed by, or in consultation with, an allergist/immunologist or gastroenterologist

## 2 . Revision History

Date	Notes
12/8/2025	Added Eohilia

Reblozyl



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-504228
<b>Guideline Name</b>	Reblozyl
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Reblozyl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - All other causes of anemia (e.g., nutritional deficiencies, viral infection, environmental factors, marrow suppressing medications) have been evaluated and treated, if applicable

**AND**

**3** - Females of reproductive potential have obtained a negative pregnancy test prior to start of therapy and have been advised to use an effective method of contraception during treatment and at least for three months after treatment

**AND**

**4** - Medication is being dosed per FDA-label

**AND**

**5** - Prescribed by, or in consultation with, a hematologist or oncologist

**AND**

**6** - ONE of the following:

**6.1** ALL of the following:

- Diagnosis of beta thalassemia
- Patient does not have Hemoglobin S/beta-thalassemia or alpha-thalassemia
- Patient has not had a transfusion-free period greater than 35 days in the past 24 weeks

**OR**

**6.2** ALL of the following:

- Diagnosis of myelodysplastic syndromes with ring sideroblasts (MDS-RS) or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)
- Patient has very low- to intermediate-risk disease
- Patient has experienced inadequate response to prior treatment with erythropoiesis-stimulating agent (ESA) therapy

<ul style="list-style-type: none"> <li>• Patient has required at least two units of packed red blood cells (pRBCs) in the prior eight weeks</li> <li>• If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>6.3 ALL of the following:</b></p> <ul style="list-style-type: none"> <li>• Diagnosis of myelodysplastic syndromes (MDS)</li> <li>• Patient has very low- to intermediate-risk disease</li> <li>• Patient is erythropoiesis-stimulating agent (ESA)-naïve (without prior ESA use)</li> </ul>	
Notes	*PDL: <a href="https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html">https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html</a>

Product Name:Reblozyl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (e.g. decrease in the number of RBC transfusions, increase in baseline hemoglobin)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Medication is prescribed by, or in consultation with, a hematologist or oncologist</p>	

## 2 . Revision History

Date	Notes
1/22/2026	New program



Rectiv



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-438188
<b>Guideline Name</b>	Rectiv
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Rectiv ointment, generic nitroglycerin ointment	
Diagnosis	Pain Associated with Chronic Anal Fissures

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Approval Length	12 month(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b> 1 - Diagnosis of moderate to severe pain associated with chronic anal fissures	

## 2 . Revision History

Date	Notes
11/5/2025	Combined formularies - added MI, NV, VA, IN, NE, NM. No clinical changes.

Repository Corticotropins



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442211
<b>Guideline Name</b>	Repository Corticotropins
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Acthar, Cortrophin	
Diagnosis	Infantile spasm (i.e., West Syndrome)*
Approval Length	1 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of infantile spasms (i.e., West Syndrome)\*

**AND**

2 - Patient is less than 2 years old

Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.
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Product Name: Acthar, Cortrophin	
Diagnosis	Opsoclonus-myoclonus syndrome (i.e., Kinsbourne Syndrome)*
Approval Length	3 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of opsoclonus-myoclonus syndrome (i.e., Kinsbourne Syndrome)*</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - If the request is for Acthar gel, provider submits documentation of reason or special circumstance patient cannot use Cortrophin Gel</p>	
Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.

**2 . Background**

Benefit/Coverage/Program Information
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**More Information:**

The Acthar Gel and Purified Cortrophin Gel package inserts have listed other conditions in which it may be used. UHCP has determined that use of Acthar Gel and Purified Cortrophin Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

**3 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Respirator and Allergy Biologics



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512252
<b>Guideline Name</b>	Respirator and Allergy Biologics
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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### 1 . Criteria

Product Name:Xolair	
Diagnosis	Moderate to severe persistent asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of moderate to severe persistent asthma</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient is 6 years of age or older

**AND**

**3** - The patient has a history of a positive skin test or radioallergosorbent (RAST) test to a perennial aeroallergen

**AND**

**4** - Prescribed by one of the following:

- Pulmonologist
- Allergist/Immunologist

**AND**

**5** - The patient has had an inadequate response, adverse reaction, or contraindication to inhaled corticosteroids

**AND**

**6** - The patient has had an inadequate response, adverse reaction, or contraindication to a leukotriene receptor antagonist

**AND**

**7** - The patient has a pretreatment serum total Immunoglobulin E (IgE) level between 30 IU/mL and 700 IU/mL (document IgE)

**AND**

**8** - The patient's current weight is recorded (please document patient weight)

**AND**

**9** - The requested dose is appropriate for the patient’s pre-treatment serum IgE and body weight per Table 1 in background

**AND**

**10** - The patient will NOT use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies

**AND**

**11** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Xolair	
Diagnosis	Chronic idiopathic urticaria (CIU)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of chronic idiopathic urticaria (CIU)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**3** - The patient has had an inadequate response, adverse reaction, or contraindication to two different oral second-generation antihistamines

**AND**

**4** - The patient has had an inadequate response, adverse reaction, or contraindication to an oral second-generation antihistamine in combination with a leukotriene receptor antagonist

**AND**

**5** - Prescribed by, or documentation that consultation regarding diagnosis and treatment recommendations was done by, one of the following:

- Allergist/immunologist
- Dermatologist
- Rheumatologist

**AND**

**6** - One of the following:

**6.1** The request is for initiation of therapy and the dose will be 150 mg every four weeks

**OR**

**6.2** The request is for initiation of therapy and the dose will be 300 mg every four weeks, and submission of medical records confirming clinical rationale for starting therapy at 300 mg every four weeks

**OR**

**6.3** The request is for continuation of therapy and the dose will be 150 mg or 300 mg every four weeks

**AND**

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Xolair

Diagnosis	Nasal Polyps (NP)
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Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - The patient has a diagnosis of Nasal Polyps (NP)

**AND**

2 - The patient is 18 years of age or older

**AND**

3 - The patient has had an inadequate response, adverse reaction, or contraindication to at least 2 months of therapy with an intranasal corticosteroid

**AND**

4 - Prescribed by, or documentation that consultation regarding diagnosis and treatment recommendations was done by, one of the following:

- Allergist/immunologist
- Dermatologist
- Rheumatologist

**AND**

5 - One of the following:

**5.1** The patient will continue intranasal corticosteroid treatment along with omalizumab therapy

**OR**

**5.2** The prescriber has provided valid medical rationale for not continuing intranasal corticosteroid treatment along with omalizumab therapy (please document rationale)

**OR**

**5.3** The request is for continuation of therapy and there is documentation of a positive clinical response to therapy (e.g., reduction in NP score [NPS; 0-8 scale], improvement in nasal congestion/obstruction score [NCS; 0-3 scale])

**AND**

**6** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:Cinqair	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of severe eosinophilic-phenotype asthma</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 18 years of age or older</p>	

**AND**

**3** - Prescribed by one of the following:

- Pulmonologist
- Allergist/Immunologist

**AND**

**4** - The patient is uncontrolled on current therapy including high dose corticosteroid and/or on a secondary asthma inhaler

**AND**

**5** - There is documentation of the patient's vaccination status

**AND**

**6** - The requested dose is 3 mg/kg (milligrams/kilogram) via IV (intravenous) infusion of 20 to 50 minutes every four weeks

**AND**

**7** - The patient will NOT use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies

**AND**

**8** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Nucala

Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of severe asthma</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Asthma is an eosinophilic phenotype as defined by ONE of the following:</p> <ul style="list-style-type: none"> <li>• Baseline (pre-treatment) peripheral blood eosinophil level 150 cells/microliter or more</li> <li>• Peripheral blood eosinophil levels were 300 cells/microliter or more within the past 12 months</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - ONE of the following:</p> <ul style="list-style-type: none"> <li>• The patient has had at least one or more asthma exacerbations requiring systemic corticosteroid within the past 12 months</li> <li>• The patient has had prior intubation for an asthma exacerbation</li> <li>• The patient has had prior asthma-related hospitalization within the past 12-months</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>4 - The patient is currently being treated with ONE of the following (unless there is a contraindication or intolerance to these medications):</p> <p>4.1 BOTH the following:</p> <ul style="list-style-type: none"> <li>• High dose inhaled corticosteroid (ICS) (e.g., &gt; 500 mcg fluticasone propionate equivalent/day)</li> <li>• Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline)</li> </ul>	

**OR**

**4.2** One maximally dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

**AND**

**5** - The patient is at least 6 years of age

**AND**

**6** - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (e.g. reduction in exacerbations, improvement in forced expiratory volume in one second [FEV1], decreased use of rescue medications)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications:</p> <p><b>2.1</b> BOTH the following:</p>	

- ICS
- Additional asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)

**OR**

**2.2** A combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

**AND**

**3** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Allergy/Immunologist

Product Name:Nucala, Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of Eosinophilic Granulomatosis with Polyangiitis (EGPA)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**3** - The patient’s disease has relapsed or is refractory to standard of care therapy (i.e. corticosteroid treatment with or without immunosuppressive therapy)

**AND**

**4** - The patient is currently receiving corticosteroid therapy

**AND**

**5** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Nucala, Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Documentation of positive clinical response to therapy (e.g. increase in remission time)

**AND**

**2** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of uncontrolled Hypereosinophilic Syndrome (HES) for at least 6 months defined by both of the following:</p> <ul style="list-style-type: none"> <li>• History of at least 2 flares over the past 12 months</li> <li>• Baseline (pre-treatment) blood eosinophil count greater than or equal to 1,000 cells/mL (cells/milliliter)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - There is no identifiable non-hematologic secondary cause of the HES</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Patient does NOT have FIP1L1-PDGFRa kinase-positive HES</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Patient is currently receiving a stable dose of background HES therapy (e.g., episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy)</p> <p style="text-align: center;"><b>AND</b></p>	

**6** - Prescribed by, or in consultation with, one of the following:

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Product Name:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (e.g., decreased number of flares, improved fatigue, reduced corticosteroids requirements, and decreased eosinophil levels)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Allergist</li> <li>• Immunologist</li> <li>• Pulmonologist</li> <li>• Rheumatologist</li> </ul>	

Product Name:Nucala	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of Chronic Rhinosinusitis with nasal polyps (CRSwNP)

**AND**

2 - Patient is 18 years of age or older

**AND**

3 - Unless contraindicated, the patient has had an inadequate response to at least two months of treatment with an intranasal corticosteroid

**AND**

4 - The requested medication will be used as add-on medication to maintenance therapy (e.g. intranasal corticosteroid, saline nasal irrigations, systemic corticosteroids, antibiotics)

**AND**

5 - Prescribed by or in consultation with ONE of the following:

- Allergist/immunologist
- Otolaryngologist/ENT

Product Name:Nucala	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of Chronic Rhinosinusitis with nasal polyps (CRSwNP)

**AND**

2 - Patient is 18 years of age or older

**AND**

3 - The requested medication will be used as add-on medication to maintenance therapy (e.g. intranasal corticosteroid, saline nasal irrigations, systemic corticosteroids, antibiotics)

**AND**

4 - Documentation of positive clinical response to Nucala (mepolizumab)

**AND**

5 - Prescribed by or in consultation with ONE of the following:

- Allergist/immunologist
- Otolaryngologist/ENT

Product Name:Fasenra	
Diagnosis	Severe eosinophilic phenotype asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - The patient has a diagnosis of severe eosinophilic phenotype asthma

**AND**

2 - The patient is 6 years of age or older

**AND**

3 - The requested medication is dosed per FDA (Food and Drug Administration) label based on age and weight

**AND**

4 - One of the following:

- Patient has had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

**AND**

5 - One of the following:

5.1 Patient is currently being treated with one of the following:

- Both a high-dose ICS (inhaled corticosteroid) [e.g., greater than 500 micrograms (mcg) fluticasone propionate equivalent/day] and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**OR**

5.2 Patient has a contraindication or intolerance to all of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**AND**

**6** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Allergy/Immunology specialist

**AND**

**7** - The patient will NOT use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies

Product Name:Fasenra	
Diagnosis	Severe eosinophilic phenotype asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - There is documentation of a positive clinical response (e.g., reduction in exacerbation)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - One of the following:</p> <p><b>2.1</b> Patient is currently being treated with one of the following:</p>	

- Both an ICS (inhaled corticosteroid) and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- A combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

**OR**

**2.2** Patient has a contraindication or intolerance to all of the following:

- ICS
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

**AND**

**3** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Allergy/Immunology specialist

Product Name: Dupixent, Nemluvio, Ebglyss	
Diagnosis	Moderate to severe atopic dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of moderate to severe atopic dermatitis</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergy/Immunologist
- Otolaryngologist

**AND**

**3** - One of the following:

**3.1** Trial and failure, contraindication, or intolerance to one medium to high potency topical corticosteroid (e.g. betamethasone, triamcinolone)

**OR**

**3.2** Trial and failure, or intolerance to one of the following, unless the patient is not a candidate for therapy (e.g. immunocompromised):

- Pimecrolimus topical cream
- Tacrolimus topical ointment

**AND**

**4** - If the request is for Nemluvio, BOTH of the following:

- The patient is at least 12 years of age
- Medication will be used in combination with topical corticosteroids and/or calcineurin inhibitors

**AND**

**5** - If the request is for Ebglyss, BOTH of the following:

- The patient is at least 12 years of age
- The patient weighs at least 40 kg

**AND**

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**6** - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Dupixent, Nemluvio, Ebglyss

Diagnosis	Moderate to severe atopic dermatitis
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Approval Length	12 month(s)
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Therapy Stage	Reauthorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - There is documentation of a positive clinical response to therapy

**AND**

2 - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist/Immunologist
- Otolaryngologist

Product Name: Dupixent

Diagnosis	Asthma
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Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - Diagnosis of moderate to severe asthma

**AND**

**2 - ONE** of the following:

**2.1** The patient is currently dependent on oral corticosteroids for the treatment of asthma and one of the following:

- One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

**OR**

**2.2 BOTH** of the following:

**2.2.1** Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

**AND**

**2.2.2 ONE** of the following:

- One or more asthma exacerbations requiring systemic corticosteroid within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

**AND**

**3 - ONE** of the following:

**3.1** Patient is currently being treated with **ONE** of the following:

- Both a high-dose ICS (inhaled corticosteroid) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]

- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**OR**

**3.2** Patient has a contraindication or intolerance to ALL of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**AND**

**4** - The patient is 6 years of age or older

**AND**

**5** - Prescribed by, or in consultation with, ONE of the following:

- Pulmonologist
- Allergy/Immunology specialist

Product Name: Dupixent	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in FEV1, decreased use of rescue medications)</p>	

**AND**

**2 - ONE** of the following:

**2.1** Patient is currently being treated with **ONE** of the following:

- Both a high dose ICS (e.g., > 500mcg fluticasone propionate equivalent/day) and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**OR**

**2.2** Patient has a contraindication or intolerance to **ALL** of the following:

- High dose ICS
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**AND**

**3 - Prescribed by, or in consultation with, one of the following:**

- Pulmonologist
- Allergy/Immunology specialist

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of Chronic Rhinosinusitis with nasal polyps (CRSwNP)

**AND**

2 - Patient is 12 years of age or older

**AND**

3 - Unless contraindicated, the patient has had an inadequate response to at least two months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone) (Please document drug(s), dose, duration, and date of trial)

**AND**

4 - The requested medication will NOT be used in combination with another biologic therapy (e.g., Nucala, Xolair) for CRSwNP

**AND**

5 - Prescribed by, or in consultation with, an allergist/immunologist/otolaryngologists/ENTs

Product Name: Dupixent	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - Documentation of positive clinical response to the requested therapy

**AND**

2 - The requested medication will NOT be used in combination with another biologic therapy (e.g., Nucala, Xolair) for CRSwNP

**AND**

3 - Prescribed by, or in consultation with, an allergist/immunologist/otolaryngologists/ENTs

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Eosinophilic Esophagitis (EoE)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 1 year of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient weighs at least 15 kg (kilograms)</p> <p style="text-align: center;"><b>AND</b></p>	

**4** - The requested medication is dosed per FDA (Food and Drug Administration) label based on age and weight

**AND**

**5** - Prescribed by, or in consultation with, an allergist/immunologist or gastroenterologist

**AND**

**6** - Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to requested therapy</p> <p><b>AND</b></p> <p><b>2</b> - Prescribed by, or in consultation with an, allergist or gastroenterologist</p>	

Product Name: Dupixent, Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of Prurigo Nodularis (PN)

**AND**

2 - Patient is 18 years of age or older

**AND**

3 - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

**AND**

4 - If the request is for a non-preferred\* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Dupixent, Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to requested therapy</p>	

**AND**

**2** - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Dupixent, Nucala	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient has confirmed diagnosis of inadequately controlled Chronic Obstructive Pulmonary Disease (COPD) with eosinophilic phenotype, defined by BOTH of the following:</p> <p><b>1.1</b> History of greater than or equal to 2 moderate exacerbations or greater than or equal to 1 severe exacerbation within the past 12 months</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2</b> ONE of the following:</p> <ul style="list-style-type: none"> <li>• For Dupixent: Blood eosinophil count greater than or equal to 300 cells/microliter</li> <li>• For Nucala: Blood eosinophil count greater than or equal to 150 cells/microliter</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 18 years of age or older</p>	

**AND**

**3** - Inadequate response, intolerable adverse effects, or contraindications to at least a 3-month trial of ALL of the following treatments:

- LABA (long-acting beta-agonist)
- LAMA (long-acting muscarinic antagonist/anticholinergic)
- ICS (inhaled corticosteroid) [Note: trial of double therapy (LABA plus LAMA) permitted if ICS is contraindicated]

**AND**

**4** - Patient will continue to receive maintenance therapy concomitantly with the requested medication

**AND**

**5** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Allergist/immunologist

Product Name: Dupixent, Nucala	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response to requested therapy	

**AND**

**2** - Patient continues to receive maintenance therapy concomitantly with the requested medication

**AND**

**3** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Allergist/immunologist

Product Name: Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of Chronic Spontaneous Urticaria (CSU)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient has experienced spontaneous onset urticaria with no known cause, with or without angioedema</p>	

**AND**

**4** - Patient had an inadequate response, intolerable adverse effects, or contraindication to an H1 antihistamine

**AND**

**5** - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to requested therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Dermatologist</li> <li>• Allergist</li> <li>• Immunologist</li> </ul>	

Product Name: Dupixent
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Diagnosis	Bullous Pemphigoid (BP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Bullous Pemphigoid (BP)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Dermatologist</li> <li>• Allergist</li> <li>• Immunologist</li> </ul>	

Product Name: Dupixent	
Diagnosis	Bullous Pemphigoid (BP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to requested therapy</p>	

**AND**

**2** - Prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist

Product Name: Tezspire

Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Diagnosis of severe asthma

**AND**

**2** - Prescribed by, or in consultation with, one of the following:

- Pulmonologist
- Allergist/immunologist

**AND**

**3** - The patient is 12 years of age or older

**AND**

**4** - One of the following:

**4.1** Patient is currently being treated with one of the following:

- Both a high-dose ICS (inhaled corticosteroid) [e.g., greater than 500 micrograms (mcg) fluticasone propionate equivalent/day] and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**OR**

**4.2** Patient has a contraindication or intolerance to all of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**AND**

**5** - One of the following:

- Patient has had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

**AND**

**6** - Medication will NOT be used in combination with other monoclonal antibodies for asthma treatment

**AND**

**7** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes

PDL link: <https://myhpnmedicaid.com/member/pharmacy-benefits>

Product Name: Tezspire	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of severe asthma</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Pulmonologist</li> <li>• Allergist/immunologist</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - The patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - One of the following:</p> <p>4.1 Patient is currently being treated with one of the following:</p> <ul style="list-style-type: none"> <li>• Both a high-dose ICS (inhaled corticosteroid) [e.g., greater than 500 micrograms (mcg) fluticasone propionate equivalent/day] and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]</li> <li>• One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>4.2 Patient has a contraindication or intolerance to all of the following:</p>	

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS)/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

**AND**

**5** - Medication will not be used in combination with other monoclonal antibodies for asthma treatment

**AND**

**6** - Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in FEV1, decreased use of rescue medications)

Product Name: Adbry	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of moderate to severe atopic dermatitis</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Dermatologist</li> <li>• Allergy/Immunologist</li> <li>• Otolaryngologist</li> </ul>	

**AND**

**3** - One of the following:

**3.1** Trial and failure, contraindication, or intolerance to one medium to high potency topical corticosteroid (e.g. betamethasone, triamcinolone)

**OR**

**3.2** Trial and failure, or intolerance to one of the following, unless the patient is not a candidate for therapy (e.g. immunocompromised):

- Pimecrolimus topical cream
- Tacrolimus topical ointment

**AND**

**4** - Patient is at least 12 years of age

Product Name:Adbry	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - There is documentation of a positive clinical response to therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by, or in consultation with, one of the following:</p> <ul style="list-style-type: none"> <li>• Dermatologist</li> <li>• Allergy/Immunologist</li> </ul>	

- Otolaryngologist

## 2 . Background

Benefit/Coverage/Program Information				
Table 1: Dosing for Xolair (omalizumab)				
Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	>60-70	>70-90	>90-150
≥30-100	150 mg	150 mg	150 mg	300 mg
>100-200	300 mg	300 mg	300 mg	225 mg
>200-300	300 mg	225 mg	225 mg	300 mg
>300-400	225 mg	225 mg	300 mg	
>400-500	300 mg	300 mg	375 mg	
>500-600	300 mg	375 mg	<b>DO NOT DOSE</b>	
>600-700	375 mg			
<b>Every 2 Weeks Dosing</b>				
<b>Every 4 Weeks Dosing</b>				

## 3 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Rezdiffra



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-458413
<b>Guideline Name</b>	Rezdiffra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Rezdiffra	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with fibrosis stage 2 or 3 confirmed by submission of medical records of at least one of the following:</p> <ul style="list-style-type: none"> <li>Liver biopsy</li> </ul>	

<ul style="list-style-type: none"> <li>• Vibration-controlled transient elastography (VCTE) (e.g., FibroScan)</li> <li>• Magnetic resonance elastography (MRE)</li> </ul>
<b>AND</b>
2 - Patient is at least 18 years of age
<b>AND</b>
3 - Patient does NOT have decompensated cirrhosis
<b>AND</b>
4 - The requested medication is prescribed by, or in consultation with, a gastroenterologist, hepatologist, or endocrinologist
<b>AND</b>
5 - One of the following: <ul style="list-style-type: none"> <li>• Patient has inadequate response, intolerance, or contraindication to Wegovy (semaglutide) for MASH treatment</li> <li>• Specialist has submitted justification to reasonably expect Wegovy (semaglutide) to be ineffective for patient’s specific treatment</li> </ul>
<b>AND</b>
6 - Prescriber attestation that the requested medication is being prescribed in conjunction with diet and exercise

Product Name: Rezdiffra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Documentation of positive clinical response to therapy

**AND**

2 - Patient is without any treatment-restricting adverse events (including hepatotoxicity or gallbladder related adverse reaction)

**AND**

3 - The requested medication is prescribed by, or in consultation with, a gastroenterologist, hepatologist, or endocrinologist

**2 . Revision History**

Date	Notes
12/8/2025	New guideline

Rezurock



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-448298
<b>Guideline Name</b>	Rezurock
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Rezurock	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of chronic graft-versus-host disease (chronic GVHD)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - History of failure of at least TWO prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, tacrolimus, etc.) confirmed by claims history or submitted medical records</p>	

Product Name: Rezurock	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Rezurock therapy</p>	

**2 . Revision History**

Date	Notes
11/12/2025	Combined formularies including NV for eff 1/1/26. No changes to clinical criteria.

Riomet (metformin solution)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-418221
<b>Guideline Name</b>	Riomet (metformin solution)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Riomet, generic metformin solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is unable to have oral tablets appropriately administered</p>	

### 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/10/2025	1/1/2026 Implementation

Roctavian



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422547
<b>Guideline Name</b>	Roctavian
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Roctavian	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by or in consultation with a hematologist</p>	

**AND**

**3** - The patient has a diagnosis of severe congenital factor VIII deficiency (e.g., pre-treatment factor VIII activity less than 1 IU/dL), as confirmed by blood coagulation testing

**AND**

**4** - The patient is on a stable dose of regularly administered exogenous factor VIII for the prevention and control of bleeding episodes

**AND**

**5** - The patient does not have an active infection, either acute (e.g., acute respiratory infection or acute hepatitis) or uncontrolled chronic (e.g., chronic active hepatitis B)

**AND**

**6** - The patient does not have significant hepatic fibrosis (stage 3 or 4) or cirrhosis

**AND**

**7** - The patient has not received prior hemophilia adeno-associated virus (AAV)-vector-based gene therapy\*

**AND**

**8** - The patient is AAV serotype 5 (AAV5) antibody negative as determined by an FDA-approved or CLIA compliant test

**AND**

**9** - The patient has been tested and found negative for active factor VIII inhibitors (e.g., results from a Bethesda assay or Bethesda assay with Nijmegen modification of under 0.6 Bethesda

Units (BU) on two consecutive occasions greater than or equal to 1 week apart within the past 12 months) and is not receiving a bypassing agent (e.g., Feiba)

**AND**

**10** - Prescriber attests to BOTH of the following:

**10.1** Factor VIII activity will be monitored periodically post-administration

**AND**

**10.2** ONE of the following:

**10.2.1** Patients with factor VIII activity levels greater than 5 IU/dL will discontinue routine prophylactic exogenous factor VIII

**OR**

**10.2.2** If factor VIII activity levels decrease and/or if bleeding is not controlled, prescriber will assess presence of factor VIII inhibitors, and assess the need for hemostatic prophylaxis

Notes	*Limited to one treatment per lifetime
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## 2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Sandostatin



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-511287
<b>Guideline Name</b>	Sandostatin
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/15/2026
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**1 . Criteria**

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of acromegaly</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 Inadequate response to ONE of the following:</p> <ul style="list-style-type: none"> <li>• Surgical resection</li> <li>• Pituitary irradiation</li> <li>• Dopamine agonist (e.g., bromocriptine, cabergoline) therapy</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2 NOT a candidate for any of the following:</p> <ul style="list-style-type: none"> <li>• Surgical resection</li> <li>• Pituitary irradiation</li> <li>• Dopamine agonist (e.g., bromocriptine, cabergoline) therapy</li> </ul>	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of meningioma</p>	

<p><b>AND</b></p> <p><b>2 - Disease is surgically inaccessible</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Disease is recurrent</li> <li>• Disease is progressive</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Radiation is not possible</b></p>
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Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Patient has a neuroendocrine tumor [i.e., carcinoid tumors, Islet cell tumors, gastrinomas, glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI (gastrointestinal) tract, lung and thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2 - BOTH of the following:</b></p> <p><b>2.1 ONE of the following:</b></p>	

- Diagnosis of Pheochromocytoma or Paraganglioma
- Well-differentiated grade 3 neuroendocrine tumor

**AND**

**2.2** Disease is ONE of the following:

- Locally unresectable
- Metastatic

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on the requested therapy</p> <p style="text-align: center;"><b>OR</b></p> <p>2 - Documentation of positive clinical response (e.g., suppression of severe diarrhea, flushing, etc.) to the requested therapy</p>	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of thymoma or thymic carcinoma

**AND**

2 - ONE of the following:

2.1 Used as a second-line therapy for ONE of the following:

- Unresectable locally advanced disease
- Solitary metastasis or ipsilateral pleural metastasis
- Extrathoracic metastatic disease

**OR**

2.2 BOTH of the following:

2.2.1 Used as first line therapy for ONE of the following:

- Potentially resectable locally advanced disease
- Potentially resectable solitary metastasis or ipsilateral pleural metastasis
- Consideration following surgery for solitary metastasis or ipsilateral pleural metastasis
- Medically inoperable/unresectable solitary metastasis or ipsilateral pleural metastasis
- Extrathoracic metastatic disease
- Postoperative treatment for thymoma after R2 resection
- Preoperative systemic therapy for surgically resectable disease if R0 resection uncertain

**AND**

2.2.2 Patient is unable to tolerate first-line combination regimens

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma, Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on the requested therapy</p>	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Malignant Bowel Obstruction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of malignant bowel obstruction</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Gut function cannot be maintained</p>	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Chemotherapy- and/or Radiation-Induced Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of diarrhea due to concurrent cancer chemotherapy and/or radiation</p>	

**AND**

**2** - ONE of the following:

**2.1** Presence of Grade 3 or 4 severe diarrhea

**OR**

**2.2** Patient is in palliative or end of life care

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Bleeding Gastroesophageal Varices
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of bleeding gastroesophageal varices associated with liver disease</p>	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p>	

Product Name: Brand Sandostatin, generic octreotide	
Diagnosis	Acromegaly, Malignant Bowel Obstruction, Chemotherapy- and/or Radiation-Induced Diarrhea, Bleeding Gastroesophageal Varices, NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to the requested therapy</p>	

## 2 . Revision History

Date	Notes
2/3/2026	Removed WA

Saphnelo (anifrolumab-fnia)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-398288
<b>Guideline Name</b>	Saphnelo (anifrolumab-fnia)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Saphnelo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is greater than or equal to 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has a diagnosis of moderate to severe systemic lupus erythematosus (SLE)

**AND**

**3** - Prescribed by or in consultation with a rheumatologist

**AND**

**4** - Patient does NOT have any of the following exclusions to therapy:

- Severe active central nervous system (CNS) lupus
- Severe active lupus nephritis (LN)

**AND**

**5** - Patient has failed to respond adequately to at least one standard therapy (e.g., antimalarials, corticosteroids, or immunosuppressives)

**AND**

**6** - The medication will be used in combination with standard therapy (e.g., antimalarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives)

**AND**

**7** - Patient does NOT have a clinically significant active infection

**AND**

**8** - Patient will NOT receive a live or live-attenuated vaccine concurrently with treatment

**AND**

**9** - The medication will NOT be used in combination with other biologic therapies, including B-cell targeted therapies (e.g., belimumab [Benlysta], voclosporin [Lupkynis], or cyclophosphamide)

Product Name:Saphnelo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Documentation of positive clinical response to Saphnelo therapy

**AND**

**2** - Patient is greater than or equal to 18 years of age

**AND**

**3** - Patient has a diagnosis of moderate to severe systemic lupus erythematosus (SLE)

**AND**

**4** - Prescribed by or in consultation with a rheumatologist

**AND**

**5** - Patient does NOT have any of the following exclusions to therapy:

- Severe active central nervous system (CNS) lupus
- Severe active lupus nephritis (LN)

**AND**

**6** - The medication will be used in combination with standard therapy (e.g., antimalarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives)

**AND**

**7** - Patient does NOT have a clinically significant active infection

**AND**

**8** - Patient will NOT receive a live or live-attenuated vaccine concurrently with treatment

**AND**

**9** - The medication will NOT be used in combination with other biologic therapies, including B-cell targeted therapies (e.g., belimumab [Benlysta], voclosporin [Lupkynis], or cyclophosphamide)

## 2 . Revision History

Date	Notes
9/22/2025	New program.

Savella



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-416254
<b>Guideline Name</b>	Savella
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Savella	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified</p>	

### 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/7/2025	New guideline

Sensipar



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-442214
<b>Guideline Name</b>	Sensipar
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Sensipar, generic cinacalcet
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Diagnosis of secondary hyperparathyroidism with chronic kidney disease</li> <li>• Patient is on dialysis</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Diagnosis of hypercalcemia with parathyroid carcinoma</p> <p style="text-align: center;"><b>OR</b></p> <p>2.3 ALL of the following:</p> <ul style="list-style-type: none"> <li>• Diagnosis of primary hyperparathyroidism (HPT)</li> <li>• Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT</li> <li>• Patient is unable to undergo parathyroidectomy</li> </ul>	

Product Name: Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient has experienced a reduction in serum calcium from baseline

**2 . Revision History**

Date	Notes
11/6/2025	Added Nevada Formulary

Sephience



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-503346
<b>Guideline Name</b>	Sephience
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Sephience	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of phenylketonuria (PKU)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Patient is actively on a phenylalanine-restricted diet</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - One of the following:</b></p> <p><b>3.1 Failure to sapropterin as confirmed by claims history or submission of medical records</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance)</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>3.3 Patient is not an appropriate candidate for sapropterin due to two null mutations in trans</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Physician attestation that the patient will not be receiving Sephience in combination with sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz)</b></p>	

Product Name: Sephience	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is actively on a Phe-restricted diet</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Blood Phe levels continue to remain lower than baseline level</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Sephience in combination with sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz) *</p>	
Notes	*Prescription claim history that does not show any concomitant sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz) claim within 60 days of reauthorization request may be used as documentation

## 2 . Revision History

Date	Notes
1/21/2026	New

Short Acting Opioids



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512253
<b>Guideline Name</b>	Short Acting Opioids
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/3/2026
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**1 . Criteria**

Product Name:butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, tramadol, Qdolo, Tramadol soln, Brand tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Requests exceeding the 7 days' supply limit
Approval Length	For patients less than 18 years of age, approval length is 3 months; For patients greater than or equal to 18 years of age, approval length is 12 months

Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p><b>1 - One of the following:</b></p> <p><b>1.1</b> The patient has filled an opioid in the past 45 days</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> All of the following:</p> <ul style="list-style-type: none"> <li>• The patient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber</li> <li>• Pain cannot be controlled through the use of non-opioid therapy [e.g., acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.]</li> <li>• The lowest effective dose is being prescribed</li> <li>• A pain contract is on file</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>1.3</b> One of the following:</p> <ul style="list-style-type: none"> <li>• Patient has cancer/malignancy related pain</li> <li>• Patient is post-surgery with an anticipated prolonged recovery (greater than 3 months)</li> <li>• Patient is receiving palliative care, hospice or end-of-life care</li> <li>• Patient is residing in a long-term care facility</li> <li>• Patient is receiving treatment for HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)</li> <li>• Prescribed by, or in consultation with, a pain specialist</li> </ul>	

Product Name: butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, tramadol,

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Qdolo, Tramadol soln, Brand tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Requests exceeding Morphine Milligram Equivalents (MME)
Approval Length	For patients less than 18 years of age, approval length is 3 months; For patients greater than or equal to 18 years of age, approval length is 12 months
Guideline Type	DUR
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 All of the following:</p> <ul style="list-style-type: none"> <li>• The patient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber</li> <li>• Pain cannot be controlled through the use of non-opioid therapy [e.g., acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.]</li> <li>• The lowest effective dose is being prescribed</li> <li>• A pain contract is on file</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>1.2 One of the following:</p> <ul style="list-style-type: none"> <li>• Patient has cancer/malignancy related pain</li> <li>• Patient is post-surgery with an anticipated prolonged recovery (greater than 3 months)</li> <li>• Patient is receiving palliative care, hospice, or end-of-life care</li> <li>• Patient is residing in a long-term care facility</li> <li>• Patient is receiving treatment for HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)</li> <li>• Prescribed by, or in consultation with, a pain specialist</li> </ul>	

Product Name:codeine, acetaminophen w/codeine soln and tabs	
Approval Length	For patients less than 18 years of age, approval length is 1 month; For patients greater than or equal to 18 years of age, approval length is 12 months

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - One of the following:</p> <p><b>1.1</b> Patient is 18 years of age or older</p> <p style="text-align: center;"><b>OR</b></p> <p><b>1.2</b> Patient is less than 18 years of age and all of the following:</p> <p><b>1.2.1</b> Patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2.2</b> The lowest effective dose for the shortest period of time is being requested</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2.3</b> The patient is not obese [BMI (body mass index) greater than 30 kilograms per square meter] and does not have obstructive sleep apnea or severe lung disease</p> <p style="text-align: center;"><b>AND</b></p> <p><b>1.2.4</b> The patient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: tramadol, Qdolo, Tramadol soln, Brand tramadol/acetaminophen	
Approval Length	For patients less than 18 years of age, approval length is 1 month; For patients greater than or equal to 18 years of age, approval length is 12 months
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 Patient is 18 years of age or older</p> <p style="text-align: center;"><b>OR</b></p> <p>1.2 Patient is less than 18 years of age and all of the following:</p> <p>1.2.1 Patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.2 The lowest effective dose for the shortest period of time is being requested</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.3 The patient is not obese [BMI (body mass index) greater than 30 kilograms per square meter] and does not have obstructive sleep apnea or severe lung disease</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2.4 The patient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy</p> <p style="text-align: center;"><b>AND</b></p>	

**1.2.5** The requested dose does not exceed 200 mg/day (milligrams per day) and does not exceed a five-day supply

**AND**

**2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:butorphanol nasal sol, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, generic oxycodone tabs, Brand Percocet, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Xyvona

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name:Brand Prolate tabs and soln

Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - Patient has had trial and failure to both of the following:

- Generic oxycodone/acetaminophen
- Generic hydrocodone/acetaminophen

**OR**

2 - Rationale provided from the prescriber as to why generic alternatives cannot be used (please document)

Product Name: Brand Prolate tabs and soln	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient continues to meet initial criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation of positive response to therapy</p>	

## 2 . Revision History

Date	Notes
2/3/2026	Updated PDL Link

Short-Acting Bronchodilators



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-512261
<b>Guideline Name</b>	Short-Acting Bronchodilators
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/4/2026
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**1 . Criteria**

Product Name: Brand Ventolin, generic albuterol sulfate HFA, Brand and generic albuterol sulfate nebulizer, Airsupra, Proair Respiclick	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
<p><b>Approval Criteria</b></p> <p>1 - The patient has a diagnosis of asthma</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - One of the following:

- The patient has been assessed for causes of asthma and external triggers have been removed or reduced where possible
- If the patient is 18 years of age or less, the patient requires an additional inhaler unit for school or equivalent program

Product Name: Brand Ventolin, generic albuterol sulfate HFA, Brand and generic albuterol sulfate nebulizer, Airsupra, Proair Respiclick

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: levalbuterol nebulizer solution, Xopenex HFA. Levalbuterol aer

Approval Length	12 month(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - One of the following:

- The patient is experiencing side effects on one other beta-adrenergic agent of any formulation
- The patient's cardiovascular status is considered to be in severe deteriorating condition

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
2/4/2026	Updated PDL Link

Sickle Cell



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422484
<b>Guideline Name</b>	Sickle Cell
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Lyfgenia	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 12 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has had genetic testing confirming diagnosis of severe sickle-cell disease (SCD) genotype ( $\beta S/\beta S$  or  $\beta S/\beta O$  or  $\beta S/\beta +$ )

**AND**

**3** - The patient does not have disease with greater than 2  $\alpha$ -globin gene deletions

**AND**

**4** - The patient has symptomatic disease with hydroxyurea or alternative approved agent unless contraindicated

**AND**

**5** - The patient experienced greater than or equal to 4 vaso-occlusive events/crises (VOE/VOC) in the previous 24-months

**AND**

**6** - Prescribed by or in consultation with a Hematologist

**AND**

**7** - Prescriber attestation that the patient is a candidate for autologous hematopoietic stem cell transplant (HSCT)

**AND**

**8** - The patient has not previously received any other SCD gene therapy, including the requested medication\* (e.g. Casgevy)

**AND**

**9** - The patient has been counseled and verbalized understanding that hematologic

malignancy (blood cancer) has occurred in clinical studies with Lyfgenia treatment (black box warning)

**AND**

**10** - The patient does not have any of the following conditions:

**10.1** Positive for presence of HIV-1 or HIV-2, HBV, HCV

**OR**

**10.2** Clinically significant and active bacterial, viral, fungal, or parasitic infection

**OR**

**10.3** Advanced liver disease

**OR**

**10.4** Inadequate bone marrow function as defined by an absolute neutrophil count of less than 1000/ $\mu$ L (

**OR**

**10.5** Any history of severe cerebral vasculopathy (defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [greater than or equal to 200 cm/sec] needing chronic transfusions, or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease

**AND**

**11** - Prescriber attestation that all necessary preparations prior to Lyfgenia administration will be followed per package insert (including scheduled transfusions to target required Hb and HbS levels and management of other concomitant medications

Notes

\*Max one treatment course per lifetime

Product Name: Casgevy	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 12 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by or in consultation with Hematologist</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescriber attestation that patient is candidate for autologous HSCT</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - The patient has not previously received an allogeneic transplant</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - The patient has not received other gene therapy for sickle-cell disease or beta-thalassemia, including the requested medication* (e.g., Lyfgenia®, Zynteglo®)</p> <p style="text-align: center;"><b>AND</b></p> <p>6 - The patient does not have any of the following conditions:</p> <p>6.1 Positive for presence of HIV-1 or HIV-2, HBV, or HCV</p> <p style="text-align: center;"><b>OR</b></p>	

**6.2** Clinically significant and active bacterial, viral, fungal, or parasitic infection

**OR**

**6.3** Advanced liver disease

**AND**

**7** - If the request is for sickle cell disease (SCD) ALL of the following:

**7.1** The patient has had genetic testing confirming diagnosis of severe SCD genotype ( $\beta\text{S}/\beta\text{S}$  or  $\beta\text{S}/\beta\text{O}$  or  $\beta\text{S}/\beta+$ )

**AND**

**7.2** The patient experienced greater than or equal to 2 VOE/VOC per year for the previous two years

**AND**

**7.3** The patient has symptomatic disease despite treatment with hydroxyurea or alternative approved agent (e.g., crizanlizumab, voxelotor), unless contraindicated

**AND**

**7.4** Prescriber attestation that all necessary preparations prior to Casgevy administration will be followed per package insert (including scheduled transfusions to target required Hb and HbS levels and discontinuation of disease modifying therapies)

**AND**

**8** - If the request is for Transfusion-dependent beta-thalassemia (TDT) ALL of the following:

**8.1** The patient has had genetic testing confirming diagnosis  $\beta$ -thalassemia

**AND**

**8.2** The patient has transfusion-dependent disease defined as a history of transfusions of greater than or equal to 100 mL/kg/year or greater than or equal to 10 units/year of packed red blood cells (pRBCs) in the previous 2 years

**AND**

**8.3** The patient does not have severely elevated iron in the heart (i.e., recipients with cardiac T2 less than 10 msec by MRI or LVEF of, less than 45% by echocardiogram)

**AND**

**8.4** Prescriber attestation that all necessary preparations prior to Casgevy administration will be followed per package insert (including scheduled transfusions to target required Hb levels and discontinuation of disease modifying therapies)

Notes	*Max 1 treatment course per lifetime
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## 2 . Revision History

Date	Notes
10/20/2025	1/1/2026 Implementation

Signifor



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-511288
<b>Guideline Name</b>	Signifor
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	2/15/2026
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**1 . Criteria**

Product Name: Signifor	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of endogenous Cushing’s disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - One of the following:</p> <ul style="list-style-type: none"> <li>• Pituitary surgery has not been curative for the patient</li> <li>• Patient is not a candidate for pituitary surgery</li> </ul>	

Product Name: Signifor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Signifor therapy</p>	

**2 . Revision History**

Date	Notes
2/3/2026	Removed WA

Skyclarys (omaveloxolone)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422490
<b>Guideline Name</b>	Skyclarys (omaveloxolone)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is at least 16 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has a diagnosis of Friedreich's ataxia as confirmed by molecular genetic testing and detection of biallelic pathogenic variant in the FXN gene and clinical signs and symptoms (e.g., ataxia, speech disturbance, sensory dysfunction, etc.) that is consistent with Friedreich's ataxia

**AND**

**3** - Prescribed by or in consultation with a neurologist, geneticist, or other specialist with advanced knowledge in treating Friedreich's ataxia

**AND**

**4** - The patient retains meaningful voluntary motor function (e.g., manipulate objects using upper extremities, ambulates)

**AND**

**5** - The patient has baseline Modified Friedreich's Ataxia Rating Scale (mFARS) score greater than 20 and less than 80

**AND**

**6** - The patient's B-Type Natriuretic Peptide (BNP) is less than or equal to 200 pg/mL prior to initiating therapy and will be monitored periodically during treatment

**AND**

**7** - Prescriber will assess both of the following prior to therapy initiation and periodically during therapy as recommended in the product label:

- Liver function (ALT, AST, bilirubin)
- Lipid parameter

**AND**

**8** - The patient does not have severe hepatic impairment (Child-Pugh C)

**AND**

**9** - The patient has the ability to swallow capsules

**AND**

**10** - If the patient has reproductive potential, they have been advised to use non-hormonal contraceptive method (e.g., non-hormonal intrauterine system, condoms) during Skyclarys therapy and for 28 days after discontinuation

Product Name: Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - The patient must have disease improvement as defined by stabilization or slowed progression of disease signs and symptoms (e.g., bulbar function, upper/lower limb coordination, upright stability) from pretreatment baseline</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient has not experienced any treatment-restricting adverse effects (e.g., fluid overload, heart failure; ALT or AST greater than 5 times the Upper Limit of Normal (ULN) or greater than 3 times the ULN with signs of liver dysfunction)</p>	

## 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/20/2025	1/1/2026 Implementation

Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combinations



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512262
<b>Guideline Name</b>	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combinations
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/4/2026
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### 1 . Criteria

Product Name:dapagliflozin (generic for Farxiga), dapagliflozin/metformin ER (generic for Xigduo XR), Inpefa, Invokamet XR, Segluromet, Steglatro, Steglujan, Trijardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - If the request is non-preferred, ONE of the following:</p> <p>1.1 Both of the following:</p> <ul style="list-style-type: none"> <li>The patient is using the requested medication for an antidiabetic indication</li> </ul>	

- The patient has tried and failed ONE preferred medication \*

**OR**

**1.2** The patient has tried and failed TWO preferred medications \*

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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## 2 . Revision History

Date	Notes
2/4/2026	Updated PDL Link

Sofdra



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-435272
<b>Guideline Name</b>	Sofdra
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Sofdra	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of primary axillary hyperhidrosis</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p>	

**2.1** Failure to Xerac-AC as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to Xerac-AC (please specify contraindication or intolerance)

## **2 . Revision History**

Date	Notes
11/4/2025	New guideline

Sohonos



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-438190
<b>Guideline Name</b>	Sohonos
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Sohonos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
	<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of fibrodysplasia ossificans progressiva (FOP)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Diagnosis has been confirmed by the presence of a mutation in the activin receptor IA (ACVR1) gene</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - ONE of the following:</p> <p><b>3.1</b> BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Patient is female</li> <li>• Patient is 8 years of age or older</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>3.2</b> BOTH of the following:</p> <ul style="list-style-type: none"> <li>• Patient is male</li> <li>• Patient is 10 years of age or older</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Sohonos is being used to reduce the volume of new heterotopic ossification (HO)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)</p>

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name: Sohonos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response [e.g., reduction in new HO (heterotopic ossification) volume, improved CAJIS (Cumulative Analogue Joint Involvement Scale) and FOP-PFQ (Fibrodysplasia Ossificans Progressiva-Physical Function Questionnaire) scores, improved quality of life]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)</p>	

**2 . Revision History**

Date	Notes
11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical changes.

Spinal Muscular Atrophy (SMA) Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-380432
<b>Guideline Name</b>	Spinal Muscular Atrophy (SMA) Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Evrysdi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Spinal Muscular Atrophy (SMA) type I, II, or III</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has mutation or deletion of genes in chromosome 5q resulting in one of the following:

**2.1** Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)

**OR**

**2.2** Compound heterozygous mutation (e.g., deletion of survival motor neuron 1 (SMN1) exon 7 [allele 1] and mutation of SMN1 [allele 2])

**AND**

**3** - Patient has at least two copies of SMN2

**AND**

**4** - Patient is not dependent on invasive ventilation or tracheostomy and non- invasive ventilation beyond use for naps and nighttime sleep

**AND**

**5** - One of the following:

**5.1** Patient is less than 2 months of age requesting Evrysdi proactively to not delay access to initial therapy in recently diagnosed infants\*

**OR**

**5.2** At least ONE of the following exams (based on the patient's age and motor ability) have been conducted to establish baseline motor ability:

- Hammersmith Infant Neurological Exam (HINE) (infant to early childhood)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test (Non ambulatory)
- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

- Motor Function Measure 32 (MFM-32) Scale

**AND**

**6** - Medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

**AND**

**7** - Patient is not receiving concomitant chronic SMN (survival motor neuron) modifying therapy for the treatment of SMA (e.g. Spinraza)

**AND**

**8** - One of the following:

**8.1** Patient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma)

**OR**

**8.2** Patient has previously received gene therapy for the treatment of SMA (e.g. Zolgensma) and the provider attests that there has been an inadequate response to gene therapy (e.g. sustained decrease in at least one motor test score over a period of six months)

Notes	*Initial assessments shortly post-therapy can serve as baseline with respect to efficacy reauthorization assessment.
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Product Name:Evrysdi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

**1** - Patient has documentation of positive clinical response to therapy from pretreatment baseline status as demonstrated by the most recent results from ONE of the following exams:

**1.1** One of the following HINE-2 milestones:

**1.1.1** Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in ability to kick

**OR**

**1.1.2** Improvement or maintenance of previous improvement of at least a one-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

**OR**

**1.1.3** Patient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

**OR**

**1.1.4** The patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

**OR**

**1.2** One of the following HFMSE milestones:

**1.2.1** Improvement or maintenance of a previous improvement of at least a three-point increase in score from pretreatment baseline

**OR**

**1.2.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

**OR**

**1.3** One of the following ULM test milestones:

**1.3.1** Improvement or maintenance of a previous improvement of at least a two-point increase in score from pretreatment baseline

**OR**

**1.3.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

**OR**

**1.4** One of the following CHOP INTEND milestones:

**1.4.1** Improvement or maintenance of a previous improvement of at least a four-point increase in score from pretreatment baseline

**OR**

**1.4.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

**OR**

**1.5** One of the following MFM-32 milestones:

**1.5.1** Improvement or maintenance of a previous improvement of at least a three-point increase in score from pretreatment baseline

**OR**

**1.5.2** Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

**AND**

**2** - Patient continues to not be dependent on invasive ventilation or tracheostomy and use of non-invasive ventilation beyond use for naps and nighttime sleep

**AND**

**3** - Medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

**AND**

**4** - Patient is not receiving concomitant chronic SMN modifying therapy for the treatment of SMA (e.g. Spinraza)

**AND**

**5** - One of the following:

**5.1** Patient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma)

**OR**

**5.2** Patient has previously received gene therapy for the treatment of SMA (e.g. Zolgensma) and the provider attests that there has been an inadequate response to gene therapy (e.g. sustained decrease in at least one motor test score over a period of six months)

Product Name: Spinraza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient has a diagnosis of Spinal Muscular Atrophy (SMA)

**AND**

2 - Medication is prescribed by or in consultation with a neurologist who has experience treating SMA

Product Name: Spinraza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient is maintaining neurological status

**AND**

2 - Patient is tolerating therapy

**AND**

3 - One of the following:

**3.1** The medication is prescribed by or in consultation with a neurologist who has experience treating SMA

**OR**

**3.2** Both of the following:

- Patient has been on therapy for 12 months or more
- Patient has experienced benefit from therapy (e.g., disease amelioration compared to untreated patients)

Product Name:Zolgensma

Approval Length	30 Day(s)
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Guideline Type	Prior Authorization
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**Approval Criteria**

1 - Patient is two years of age or younger

**AND**

2 - Patient has a mutation or deletion of genes in chromosome 5q in one of the following:

2.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

**OR**

2.2 Compound heterozygous mutation of SMN1 gene (e.g., deletion of SMN1, exon 7 [allele 1] and mutation of SMN1 [allele 2])

**AND**

3 - ONE of the following

3.1 Patient has a diagnosis of spinal muscular atrophy (SMA), which has been confirmed by a neurologist with expertise in the diagnosis of SMA

**OR**

**3.2** Patient has a diagnosis of SMA based on the results of SMA newborn screening with three copies or less of SMN2

**AND**

**4** - Patient is not dependent on either invasive ventilation or tracheostomy or use of non-invasive ventilation beyond use of naps and nighttime sleep

**AND**

**5** - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient’s anti-AAV9 antibody titers are less than or equal to 1:50

**AND**

**6** - Patient is not receiving concomitant SMN (survival motor neuron) modifying therapy (e.g. Spinraza)

**AND**

**7** - Medication is prescribed by a neurologist with expertise in the diagnosis of SMA

**AND**

**8** - Patient has NOT previously received Zolgensma treatment in their lifetime

## 2 . Revision History

Date	Notes
9/10/2025	New

Spravato



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-421296
<b>Guideline Name</b>	Spravato
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Spravato	
Approval Length	4 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 BOTH of the following:</p> <ul style="list-style-type: none"> <li>Diagnosis of treatment-resistant depression</li> </ul>	

- Diagnosis evidenced by failure of two antidepressants

**OR**

**1.2 BOTH** of the following:

- Diagnosis of depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior
- Treatment must be in conjunction with an oral antidepressant

**AND**

**2** - Patient is at least 18 years of age

**AND**

**3** - Medication must be administered under the direct supervision of a healthcare provider with post-administration observation

**AND**

**4** - Prescribed by or in consultation with a psychiatrist

**AND**

**5** - Patient does NOT have an aneurism or arteriovenous (AV) malformation

**AND**

**6** - Patient is NOT currently pregnant or breastfeeding

Product Name: Spravato	
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation of positive clinical response to treatment</p>	

**2 . Revision History**

Date	Notes
10/15/2025	New program

Strensiq (asfotase alfa)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-432189
<b>Guideline Name</b>	Strensiq (asfotase alfa)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Strensiq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia (HPP)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient was 18 years of age or younger at onset

**AND**

**3** - The patient experienced clinical manifestations of HPP (e.g., vitamin B6-responsive seizures, chest deformity, severe hypercalcemia, bowing of the long bones, failure to thrive)

**AND**

**4** - The patient obtained radiographic imaging to support diagnosis of HPP

**AND**

**5** - Genetic testing has been completed documenting tissue non-specific alkaline phosphatase (ALP) gene mutation

**AND**

**6** - There has been reduced activity of unfractionated serum ALP

**AND**

**7** - Prescribed by or in consultation with an endocrinologist, geneticist, or a metabolic disorder specialist

**AND**

**8** - The requested quantity is within FDA-labeled dosing requirement based on the patient's weight (document weight)

Product Name:Strensiq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Prescribed by or in consultation with an endocrinologist, geneticist, or a metabolic disorder specialist</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The requested quantity is within FDA-labeled dosing requirement based on the patient's weight (document weight)</p>	

## 2 . Revision History

Date	Notes
10/27/2025	New program

Stromectol



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-438197
<b>Guideline Name</b>	Stromectol
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Brand Stromectol, generic ivermectin tabs	
Approval Length	1 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Onchocerciasis due to nematode parasite</li> <li>• Pediculosis</li> <li>• Strongyloidiasis</li> <li>• Ascariasis</li> <li>• Scabies (including crusted scabies)</li> <li>• Cutaneous larva migrans (hook worm disease)</li> <li>• Enterobiasis</li> <li>• Filariasis</li> <li>• Trichuriasis</li> <li>• Gnathostomiasis</li> </ul>	

## 2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Sublingual Immunotherapy (SLIT)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-438198
<b>Guideline Name</b>	Sublingual Immunotherapy (SLIT)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Grastek	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

**AND**

**2** - Diagnosis confirmed by ONE of the following:

**2.1** Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

**OR**

**2.2** In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

**AND**

**3** - Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season

**AND**

**4** - ONE of the following:

**4.1** Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

**OR**

**4.2** History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

**AND**

**5** - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)

**AND**

**6** - Patient does not have unstable and/or uncontrolled asthma

**AND**

**7** - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Grastek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response to Grastek therapy	

Product Name:Oralair
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Diagnosis confirmed by ONE of the following:</p> <p><b>2.1</b> Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]</p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2</b> In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Treatment is started or will be started at least 4 months before the beginning of the grass pollen season</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - ONE of the following:</p> <p><b>4.1</b> Failure to TWO of the following as confirmed by claims history or submission of medical records:</p>	

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

**OR**

**4.2** History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

**AND**

**5** - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Grastek)

**AND**

**6** - Patient does not have unstable and/or uncontrolled asthma

**AND**

**7** - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name: Oralair	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	

1 - Documentation of positive clinical response to Oralair therapy

Product Name:Ragwitek

Approval Length 12 month(s)

Therapy Stage Initial Authorization

Guideline Type Prior Authorization

**Approval Criteria**

1 - Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

**AND**

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to short ragweed pollen
- In vitro testing for pollen-specific IgE (immunoglobulin E) antibodies for short ragweed pollen

**AND**

3 - Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season

**AND**

4 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]

<ul style="list-style-type: none"> <li>leukotriene inhibitor [e.g., montelukast (Singulair)]</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b>4.2</b> History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):</p> <ul style="list-style-type: none"> <li>oral antihistamine [e.g., cetirizine (Zyrtec)]</li> <li>intranasal antihistamine [e.g., azelastine (Astelin)]</li> <li>intranasal corticosteroid [e.g., fluticasone (Flonase)]</li> <li>leukotriene inhibitor [e.g., montelukast (Singulair)]</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Patient does not have unstable and/or uncontrolled asthma</p> <p style="text-align: center;"><b>AND</b></p> <p><b>6</b> - Prescribed by or in consultation with a specialist in allergy and immunology</p>
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Product Name:Ragwitek	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to Ragwitek therapy</p>	

Product Name:Odactra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of house dust mite (HDM)-induced allergic rhinitis

**AND**

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to licensed house dust mite allergen extracts
- In vitro testing for IgE (immunoglobulin E) antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites

**AND**

3 - ONE of the following:

**3.1** Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

**OR**

**3.2** History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

**AND**

4 - Patient does not have unstable and/or uncontrolled asthma

**AND**

**5** - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Odactra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Odactra therapy</p>	

## 2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Substance Abuse Agents



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512263
<b>Guideline Name</b>	Substance Abuse Agents
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/4/2026
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### 1 . Criteria

Product Name:Brand Suboxone, generic buprenorphine SL film, buprenorphine SL tab, Zubsolv, buprenorphine SL tab	
Diagnosis	Exceeding 24 mg of buprenorphine or Equivalent
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of opioid dependence</p>	

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name: Brand Suboxone, generic buprenorphine SL film, buprenorphine SL tab, Zubsolv, buprenorphine SL tab	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Brand Lucemyra, generic lofexidine	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of opioid withdrawal with symptoms due to abrupt opioid discontinuation</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The requested quantity does not exceed 2.88 mg/day (milligrams per day) for up to 14 days</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met</p>	
Notes	PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>

Product Name: Vivitrol	
Approval Length	6 month(s)

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The requested medication is being used for an FDA (Food and Drug Administration) approved indication</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - The medication will be delivered directly to the prescriber's office</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - The requested medication will only to be administered once per month</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Attestation that routine urine screening and monitoring will be completed</p>	

## 2 . Revision History

Date	Notes
2/4/2026	Updated PDL Link

Synagis (palivizumab)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-416255
<b>Guideline Name</b>	Synagis (palivizumab)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Synagis*	
Diagnosis	Patients less than 12 months of age at start of RSV season
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - One of the following:</p> <p>1.1 The patient was born at 28 weeks, six days of gestation or earlier</p> <p style="text-align: center;"><b>OR</b></p>	

**1.2** The patient has a diagnosis of chronic lung disease (CLD) of prematurity

**OR**

**1.3** The patient has hemodynamically significant congenital heart disease

**OR**

**1.4** The patient has congenital abnormalities of the airways or neuromuscular disease

**OR**

**1.5** Both of the following:

- The patient has a diagnosis of cystic fibrosis
- The patient has clinical evidence of CLD and/or nutritional compromise

**AND**

**2** - The number of doses requested do not exceed a maximum quantity of 5 per RSV (respiratory syncytial virus) season

Notes

\*Approval for up to five doses per RSV season

Product Name: Synagis\*

Diagnosis

Patients less than 24 months of age at start of RSV season

Guideline Type

Prior Authorization

**Approval Criteria**

**1** - One of the following:

**1.1** Both of the following:

- The patient has a diagnosis of chronic lung disease (CLD) of prematurity

- The patient has required medical therapy (e.g., bronchodilator, diuretics, oxygen, corticosteroids) within six months to the start of RSV (respiratory syncytial virus) season

**OR**

**1.2** The patient has had a cardiac transplant

**OR**

**1.3** The patient is severely immunocompromised (solid organ or hematopoietic stem cell transplant, chemotherapy, or other conditions) during the RSV season

**OR**

**1.4** The patient has had a cardiopulmonary bypass and continues to require prophylaxis after surgery or at the conclusion of extracorporeal membrane oxygenation

**OR**

**1.5** Both of the following:

- The patient has a diagnosis of cystic fibrosis
- The patient has had manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persists when stable) or weight for length less than the tenth percentile

**AND**

**2** - The number of doses requested do not exceed a maximum quantity of 5 per RSV (respiratory syncytial virus) season

Notes

\*Approval for up to five doses per RSV season

## 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/7/2025	New guideline

Targretin (bexarotene) 1% gel



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-449217
<b>Guideline Name</b>	Targretin (bexarotene) 1% gel
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Brand Targretin 1% gel, generic bexarotene 1% gel	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of cutaneous T-cell lymphoma (CTCL)</p>	

**AND**

**2 - ONE of the following:**

**2.1** Failure to at least one prior therapy, including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies (e.g., interferons)] as confirmed by claims history or submission of medical records

**OR**

**2.2** History of contraindication or intolerance to at least one prior therapy, including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies (e.g., interferons)] (please specify contraindication or intolerance)

Product Name: Brand Targretin 1% gel, generic bexarotene 1% gel	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Patient does not show evidence of progressive disease while on therapy	

Product Name: Brand Targretin 1% gel, generic bexarotene 1% gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name: Brand Targretin 1% gel, generic bexarotene 1% gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to therapy</p>	

**2 . Revision History**

Date	Notes
11/13/2025	New NV state specific guideline

Tarpeyo



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-438194
<b>Guideline Name</b>	Tarpeyo
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Tarpeyo	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

**AND**

2 - Patient is at risk for disease progression

**AND**

3 - Used to reduce the loss of kidney function

**AND**

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m<sup>2</sup> (milliliters/minute/1.73 square meters)

**AND**

5 - ONE of the following:

**5.1** Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submitted medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

**OR**

**5.2** Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

**AND**

**6** - ONE of the following:

**6.1** Failure of ONE 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

**OR**

**6.2** History of intolerance or contraindication to ONE glucocorticoid (please specify intolerance or contraindication)

**AND**

**7** - Prescribed by or in consultation with a nephrologist

## 2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Tavalisse



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-438193
<b>Guideline Name</b>	Tavalisse
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Tavalisse	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of chronic immune thrombocytopenia (ITP)

**AND**

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to at least ONE of the following classes confirmed by claims history or submitted medical records:

- Corticosteroids
- Immunoglobulins

**OR**

2.1.1.2 History of contraindication or intolerance to BOTH of the following classes (please specify intolerance or contraindication):

- Corticosteroids
- Immunoglobulins

**AND**

2.1.2 ONE of the following:

2.1.2.1 Failure to eltrombopag (generic Promacta) confirmed by claims history or submitted medical records

**OR**

2.1.2.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

**OR**

**2.2** Patient is currently on Tavalisse therapy

Product Name:Tavalisse	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Tavalisse therapy</p>	

## 2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Tavneos (avacopan)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422487
<b>Guideline Name</b>	Tavneos (avacopan)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Tavneos	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has severe active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis and BOTH of the following

**2.1** Patient has autoantibodies for proteinase 3 (PR3) or myeloperoxidase (MPO), as detected using indirect immunofluorescence (IIF) assay or antigen-specific ELISAs

**AND**

**2.2** Disease is confirmed by tissue biopsy at the site of active disease

**AND**

**3** - Prescribed by or in consultation with a Nephrologist, Pulmonologist, or Rheumatologist

**AND**

**4** - Prescriber has assessed baseline (pre-treatment) disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS]) (initial request only)

**AND**

**5** - Tavneos will be used as adjunctive therapy in combination with standard therapy (e.g., corticosteroids, cyclophosphamide, azathioprine, mycophenolate, rituximab)

**AND**

**6** - Patient does not have an active infection, including localized infections

**AND**

**7** - Patient does not have severe hepatic impairment (e.g., Child-Pugh C) or active, untreated, and/or uncontrolled chronic liver disease (e.g., chronic active hepatitis B, untreated hepatitis C, uncontrolled autoimmune hepatitis, cirrhosis)

**AND**

**8** - Liver panel has been obtained before initiating Tavneos and will be repeated per package insert (every four weeks after start of therapy for first six months then as clinically indicated)

**AND**

**9** - Patient has been evaluated and screened for the presence of HBV prior to initiating treatment (initial criteria only)

Product Name:Tavneos	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Documentation of positive clinical response to Tavneos therapy</p>	

**2 . Revision History**

Date	Notes
10/20/2025	1/1/2026 Implementation

Testosterone



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-435275
<b>Guideline Name</b>	Testosterone
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - ONE of the following:</p> <p>1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL</p>	

(nanograms/deciliter) [less than 10.4 nmol/L (nanomoles/liter)] or less than the reference range for the lab, taken at separate times (This may require treatment to be temporarily held. Document lab value and date for both levels)

**OR**

**1.2 BOTH** of the following:

**1.2.1** Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

**AND**

**1.2.2 ONE** pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (picograms/milliliter) (< 5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

**OR**

**1.3 Patient has a history of ONE** of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

**AND**

**2 - Patient is NOT** taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

<b>AND</b>	
3 - Patient is NOT taking any aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]	
<b>AND</b>	
4 - Patient was male at birth	
<b>AND</b>	
5 - Diagnosis of hypogonadism	
<b>AND</b>	
6 - ONE of the following:	
<ul style="list-style-type: none"> <li>• Significant reduction in weight (less than 90% ideal body weight) [e.g., AIDS (acquired immunodeficiency syndrome) wasting syndrome]</li> <li>• Osteopenia</li> <li>• Osteoporosis</li> <li>• Decreased bone density</li> <li>• Decreased libido</li> <li>• Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)</li> </ul>	
Notes	*Patients that have previously received injectable testosterone open access should be reviewed using reauthorization criteria

Product Name: Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Patient is using hormones to change physical characteristics to align with gender expression

**AND**

2 - Patient must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

**AND**

3 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

**AND**

4 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

Notes	*Patients that have previously received injectable testosterone open access should be reviewed using reauthorization criteria
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Product Name: Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism, Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - ONE of the following:

1.1 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

**OR**

1.2 BOTH of the following:

1.2.1 Patient has a diagnosis of ONE of the following:

- Hypogonadism
- Gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

**AND**

1.2.2 ONE of the following:

1.2.2.1 Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date)

**OR**

1.2.2.2 Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

**OR**

1.2.2.3 BOTH of the following:

**1.2.2.3.1** Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

**AND**

**1.2.2.3.2** ONE of the following:

- Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)
- Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

**AND**

**2** - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

**AND**

**3** - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

## 2 . Revision History

Date	Notes
11/4/2025	New guideline

Therapeutic Duplication (Subtype A)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-503398
<b>Guideline Name</b>	Therapeutic Duplication (Subtype A)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	2/1/2026
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## 1 . Criteria

Product Name:Generic arformoterol nebulizer solution, Brand Brovana nebulizer, generic formoterol nebulizer solution, Brand Perforomist nebulizer, Striverdi Respimat, Serevent Diskus, Incruse Ellipta, Brand Spiriva Handihaler, generic tiotropium, Spiriva Respimat, Tudorza Pressair, generic ipratropium inhalation solution, Atrovent HFA, Anoro Ellipta, Stiolto Respimat, Bevespi Aerosphere, Duaklir Pressair, Breztri Aerosphere, Glyxambi, Steglujan, Qtern, Trijardy XR, Brand Pulmicort suspension, generic budesonide suspension, Victoza, Adlyxin, Trulicity, Bydureon BCise, Byetta, Ozempic, Rybelsus, Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Nesina, alogliptin, Kazano, alogliptin/metformin, Oseni, alogliptin/pioglitazone, Mounjaro, Xultophy, Soliqua, Invokana, brand Farxiga, generic dapagliflozin, Jardiance, Invokamet, Invokamet XR, brand Xigduo XR, generic dapagliflozin/metformin ER, Synjardy, Synjardy XR, Steglatro, Segluromet, Zituvio, Brand Flovent HFA, Fluticasone propionate HFA, Flovent Diskus, Brand Fluticasone propionate Diskus, Brand Pulmicort Flexhaler, Alvesco, ArmonAir Digihaler, Asmanex Twisthaler, Asmanex HFA, Arnuity Ellipta, Qvar RediHaler, Lonhala Magnair, Trelegy Ellipta, Brand Advair Diskus, generic fluticasone propionate/salmeterol diskus (generic Advair Diskus),

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generic Wixela Inhub (generic Advair Diskus), AirDuo Respiclick, fluticasone/salmeterol (authorized generic of AirDuo), Brand Advair HFA, Brand Fluticasone/salmeterol HFA, Brand Symbicort, generic budesonide/formoterol, Breyna, AirDuo Digihaler, Dulera, Breo Ellipta, Brand fluticasone/vilanterol Ellipta, Basaglar Tempo pen, Basaglar Kwikpen, Insulin Glargine Solostar, Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar, Semglee Pen Injector, Insulin Glargine-YFGN pen, Lantus vial, Insulin Glargine vial, Semglee vial, Insulin Glargine-YFGN vial, Levemir vial, Levemir Flextouch, Levemir Flexpen, Tresiba vial, Insulin Degludec vial, Tresiba Flextouch, Insulin Degludec Flextouch, Rezvoglar, Baclofen tabs, generic baclofen suspension, Brand Fleqsuvy, Brand Ozobax DS, brand Ozobax, Brand Baclofen solution, brand Lioresal intrathecal, generic baclofen intrathecal, brand Gablofen intrathecal, baclofen intrathecal solution, Lyvispah, generic carisoprodol tab, brand Soma, brand Vanadom tab, generic chlorzoxazone, brand Lorzone, generic cyclobenzaprine, brand Fexmid, generic cyclobenzaprine ER, brand Amrix, metaxalone, methocarbamol, orphenadrine CR/ER, generic tizanidine caps/tabs, brand Zanaflex caps/tabs, brand Dantrium, generic dantrolene, brand Norgesic, generic orphenadrine/aspirin/caffeine, norgesic forte, orphengesic forte, Brand Neurontin caps/tabs/soln, generic gabapentin caps/tabs/soln, gabapentin tinytabs, brand Lyrica caps/soln, generic pregabalin caps/soln, brand Gralise, brand Lyrica CR, generic pregabalin ER, Horizant, Zorvolex, brand Zipsor, generic diclofenac caps, brand Lofena, generic diclofenac tabs, diclofenac DR/ER, brand Cambia, generic diclofenac packet (migraine), etodolac cap, brand Lodine, generic etodolac tab, etodolac ER, brand Nalfon caps/tabs, generic fenoprofen caps/tabs, flurbiprofen, ibuprofen caps/tabs/chewable (includes All Manufactures), Brand Advil, ibuprofen suspension (40 mg/ml & 100 mg/5ml), indomethacin caps, indomethacin ER/SR caps, indocin susp, indocin suppository, indomethacin suppository, ketoprofen cap, ketoprofen ER cap, ketorolac tabs, meclufenamate cap, mefenamic acid, meloxicam cap/tab, brand Relafen DS, generic nabumetone, generic naproxen tab/susp/caps (includes All Manufactures), brand naprosyn tab/susp, brand Aleve, brand Anaprox DS, brand EC-Naprosyn, generic naproxen DR, generic EC-naproxen, brand Naprelan, generic naproxen CR/ER, Brand Daypro, generic oxaprozin, brand Feldene, generic piroxicam, sulindac, tolmetin, brand Celebrex, generic celecoxib, Elyxyb, brand Arthrotec, generic diclofenac sodium/misoprostol, brand Duexis, generic ibuprofen/famotidine, brand Vimovo, generic naproxen/esomeprazole, brand Advil PM, generic ibuprofen/diphenhydramine, brand Aleve PM, generic naproxen/diphenhydramine, hydrocodone/ibuprofen, brand Treximet, generic sumatriptan/naproxen, Motrin Dual Action/Tylenol, Advil Dual Action/acetaminophen, acetaminophen/ibuprofen, Naproxen/capsaicin cream (Naprotin), Inpefa, Saxenda, Wegovy inj/tab, Brand Brenzavvy, Brand Bexagliflozin, Zepbound, Coxanto, Jantoven, warfarin tabs, Pradaxa, generic dabigatran, Eliquis, Savaysa, Xarelto, Zituvimet, Sitagliptin/metformin, Brand Tanlor, Dolobid, generic diflunisal, Zituvimet XR, Tresni, Fenopron, Gabarone, Addaprin, Symbravo, Exenatide, Brynovin, Vyscoxa, Tonmya

Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Administrative

**Approval Criteria**

**1** - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

**OR**

**2** - All of the following:

**2.1** The requested medication combination is supported by information from **ONE** of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

**AND**

**2.2** The drug combination is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

**AND**

**2.3** The provider attests that they are aware that the patient is using duplicate therapy

**AND**

**2.4** Special clinical circumstances exist that necessitate the need for duplicate therapy (document special circumstances)

**AND**

**2.5** Provider attests that the necessity for continued concomitant therapy and safety will be periodically assessed

## **2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
1/21/2026	Added Wegovy tab, Vyscoxa, Tonmya

Therapeutic Duplication (Subtype B)



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-507189
<b>Guideline Name</b>	Therapeutic Duplication (Subtype B)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Kansas (ACUKS, ACUKSC, ACUKSEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State North Carolina (ACUNC)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Texas (ACUTX, ACUTXC, ACUTXEC, ACUTXSK)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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## 1 . Criteria

Product Name:(All formulations/packaging, except for Entyvio) Entyvio Pen, Stelara, Cimzia, Abrilada, Humira, Amjevita, Idacio, Hulio, Cyltezo, Yusimry, Yuflyma, Hadlima, Hyrimoz, Adalimumab (all products), Simponi, Enbrel, Actemra, Cosentyx, Ilaris, Kineret, Kevzara, Taltz, Tremfya, Orencia, Xeljanz, Xeljanz XR, Xeljanz Solution, Siliq, Otezla, Olumiant, Ilumya, Skyrizi, Rinvoq, Sotyktu, Cibinco, Adbry, Dupixent, brand Copaxone, generic glatiramer acetate, generic glatopa, Mavenclad, Rebif, Avonex, Betaseron, Extavia, brand Aubagio, generic teriflunomide, Plegridy, Lemtrada, Tysabri, Ocrevus, brand Tecfidera, generic dimethyl fumarate, Vumerity, brand Gilenya, generic fingolimod, Tascenso ODT, Zeposia, Mayzent, Bafiertam, Kesimpta, Ponvory, Xolair, Fasenra, Nucala, Cinqair, Tezspire, Velsipity, Bimzelx, Omvoh, Zymfentra, Simlandi, Spevigo, Tyenne, Rinvoq LQ, Nemludio, Ebglyss, Wezlana, Steqeyma, Yesintek, Pyzchiva, Otulfi, Selarsdi, Imuldosa, Ustekinumab (all products), Leqselvi, Litfulo, Avtozma, Otezla XR, Starjemza, Exdensur	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Administrative
<p><b>Approval Criteria</b></p> <p>1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued</p>	

## 2 . Revision History

Date	Notes
1/22/2026	Added TX

Tolvaptan



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-439214
<b>Guideline Name</b>	Tolvaptan
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Jynarque, generic tolvaptan tab, generic tolvaptan pack	
Diagnosis	Autosomal dominant polycystic kidney disease (ADPKD)
Approval Length	12 month(s)

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Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)	
Notes	This criteria comes from the Jynarque policy.

Product Name:Brand Jynarque, generic tolvaptan tab, generic tolvaptan pack	
Diagnosis	Autosomal dominant polycystic kidney disease (ADPKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response to therapy	
Notes	This criteria comes from the Jynarque policy.

Product Name:Brand Samsca, generic tolvaptan tab	
Diagnosis	Hypervolemic or Euvolemic Hyponatremia
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - ONE of the following:	
<ul style="list-style-type: none"> <li>• Diagnosis of clinically significant euvolemic hyponatremia</li> <li>• Diagnosis of clinically significant hypervolemic hyponatremia</li> </ul>	

<b>AND</b>	
2 - Patient has not responded to fluid restriction	
<b>AND</b>	
3 - Treatment has been initiated or re-initiated in a hospital setting prior to discharge	
Notes	This criteria comes from the Samsca policy.

## 2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Tonmya



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-522238
<b>Guideline Name</b>	Tonmya
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	3/1/2026
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### 1 . Criteria

Product Name: Tonmya	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of fibromyalgia

**AND**

2 - Fibromyalgia diagnosed based on ALL of the following American College of Rheumatology criteria:

2.1 Generalized pain, defined as pain in at least 4 of 5 regions, is present

**AND**

2.2 Symptoms have been present at a similar level for at least 3 months

**AND**

2.3 Diagnosis of fibromyalgia is valid irrespective of other diagnoses

**AND**

2.4 Diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses

**AND**

2.5 ONE of the following:

- Widespread pain index (WPI) greater than or equal to 7 and symptom severity scale (SSS) score greater than or equal to 5
- WPI of 4–6 and SSS score greater than or equal to 9

**AND**

**3** - Patient has implemented ALL of the following nonpharmacologic measures for the treatment of fibromyalgia:

- Patient education (e.g., sleep hygiene)
- Physical activity and exercise
- Cognitive therapy (e.g., meditation and relaxation, cognitive-behavioral therapy, mindfulness-based stress reduction)

**AND**

**4** - History of failure or intolerance to cyclobenzaprine (generic Flexeril) (please specify intolerance or contraindication) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)

**AND**

**5** - One of the following:

**5.1** Failure to TWO of the following as confirmed by claims history of submission of medical records:

- amitriptyline (generic Elavil)
- duloxetine (generic Cymbalta)
- gabapentin (generic Neurontin)
- pregabalin (generic Lyrica)

**OR**

**5.2** History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- amitriptyline (generic Elavil)
- duloxetine (generic Cymbalta)
- gabapentin (generic Neurontin)
- pregabalin (generic Lyrica)

Product Name: Tonmya

Approval Length

12 month(s)

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b> 1 - Documentation of a reduction in pain intensity with Tonmya use	

## 2 . Revision History

Date	Notes
2/16/2026	New guideline

Topical Immunomodulators



**Prior Authorization Guideline**

<b>Guideline ID</b>	GL-506302
<b>Guideline Name</b>	Topical Immunomodulators
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name: Brand Elidel, Generic Pimecrolimus, Eucrisa, Tacrolimus Oint 0.03%, Tacrolimus Oint 0.1%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient meets the appropriate diagnosis for the requested product:</p> <ul style="list-style-type: none"> <li>Brand Elidel, generic pimecrolimus, Eucrisa: Mild to moderate atopic dermatitis</li> <li>Tacrolimus Ointment: Moderate to severe atopic dermatitis</li> </ul>	

**AND**

**2** - The patient meets the appropriate age limit for the requested product:

- Brand Elidel, generic pimecrolimus, Tacrolimus Oint 0.03%: Patient is 2 years of age or older
- Eucrisa: Patient is 3 months of age or older
- Tacrolimus Oint 0.1%: Patient is 16 years of age or older

**AND**

**3** - The medication is not for chronic use

**AND**

**4** - Patient is NOT immunocompromised

**AND**

**5** - If the request is for Elidel (pimecrolimus), patient does not have Netherton's syndrome

Product Name:Opzelura	
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Approval Length	12 month(s)
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Therapy Stage	Initial Authorization
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Guideline Type	Prior Authorization
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**Approval Criteria**

**1** - Diagnosis of mild to moderate Atopic Dermatitis

**AND**

**2** - Patient is 2 years of age or older

<b>AND</b>
<b>3</b> - The medication will not be used chronically
<b>AND</b>
<b>4</b> - Patient is NOT immunocompromised
<b>AND</b>
<b>5</b> - Patient has had a trial and failure, contraindication, or intolerance to two or more of the following classes:
<ul style="list-style-type: none"> <li>• Prescription topical corticosteroids</li> <li>• Topical calcineurin inhibitor (e.g., Elidel (pimecrolimus) or Protopic (tacrolimus))</li> <li>• Topical phosphodiesterase-4 inhibitor (e.g., Eucrisa (crisaborole))</li> </ul>

Product Name: Opzelura	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
<b>1</b> - Patient has had disease improvement and/or stabilization	

Product Name: Anzupgo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of moderate to severe chronic hand eczema (CHE)

**AND**

2 - Patient is at least 18 years of age

**AND**

3 - ONE of the following:

- Hand eczema has persisted for more than 3 months
- Hand eczema has returned twice or more within the last 12 months

**AND**

4 - Patient has had an inadequate response, intolerance, or contraindication to at least 1 moderate to high potency topical corticosteroid

**AND**

5 - Medication will NOT be used concurrently with Opzelura (ruxolitinib), systemic JAK inhibitors, or potent immunosuppressants

**AND**

6 - Patient does NOT have an active or serious infection

Product Name: Anzupgo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response</p>	

## 2 . Revision History

Date	Notes
1/26/2026	Added Anzupgo. Updated age criteria for Opzelura

Toradol (ketorolac tromethamine) tablets



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-416243
<b>Guideline Name</b>	Toradol (ketorolac tromethamine) tablets
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:ketorolac tablets	
Approval Length	Up to 5 days
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The requested oral treatment is for continuation therapy to intravenous (IV)/intramuscular (IM) therapy</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The requested oral treatment will not exceed 5 days

**AND**

**3** - The requested oral treatment will not exceed 40 milligrams per day

## **2 . Revision History**

Date	Notes
10/6/2025	New guideline

Tranexamic acid



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-443193
<b>Guideline Name</b>	Tranexamic acid
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:tranexamic acid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of cyclic heavy menstrual bleeding

**2 . Revision History**

Date	Notes
11/6/2025	Updated guideline name to Tranexamic acid. Removed Lysteda from guideline (obsolete). Combined formularies - added NV, VA, NE, NM, PA CAID

Tryngolza (olezarsen)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-391198
<b>Guideline Name</b>	Tryngolza (olezarsen)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Tryngolza	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by one of the following:

**2.1** Genetic confirmation of bi-allelic pathogenic variants in affected genes (e.g., LPL, ApoA5, ApoC2, LMF1, GPIHBPI, G3PDH1)

**OR**

**2.2** ALL of the following:

**2.2.1** Fasting triglyceride (TG) levels persistently >880 mg/dL while on conventional lipid lowering therapy, unless contraindicated or not tolerated (e.g., fibrates, omega-3 fatty acids, statins, niacin, ezetimibe)

**AND**

**2.2.2** Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease (CKD), hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens])

**AND**

**2.2.3** The patient has a clinical history suggestive of FCS (e.g., pancreatitis, eruptive xanthomas, lipemia retinalis)

**AND**

**3** - The patient has been counseled to follow a low-fat diet

**AND**

**4** - Prescribed by, or in consultation with, an endocrinologist, cardiologist, or lipidologist

Product Name: Tryngolza	
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation of positive response to therapy</p>	

**2 . Revision History**

Date	Notes
9/8/2025	1/1/2026 implementation

Tryvio



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434331
<b>Guideline Name</b>	Tryvio
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name: Tryvio
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of resistant hypertension</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <ul style="list-style-type: none"> <li>• Systolic blood pressure greater than or equal to 130 mm Hg (millimeters of mercury) on two consecutive measurements despite maximally tolerated antihypertensive treatment</li> <li>• Diastolic blood pressure greater than or equal to 80 mm Hg on two consecutive measurements despite maximally tolerated antihypertensive treatment</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - Patient has been previously treated with ALL of the following antihypertensive classes for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose as confirmed by claims history or submission of medical records:</b></p> <ul style="list-style-type: none"> <li>• Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]</li> <li>• Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)</li> <li>• Maximally tolerated diuretics (e.g., hydrochlorothiazide)</li> <li>• Maximally tolerated mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)]</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>4 - Provider attests other causes of hypertension have been excluded (e.g., secondary causes [e.g., primary hyperaldosteronism], white coat effect, medication nonadherence)</b></p>	

**AND**

**5** - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

**AND**

**6** - Tryvio will be used in combination with at least 3 antihypertensive medications from different classes at maximally tolerated doses

**AND**

**7** - Prescribed by or in consultation with a specialist experienced in the treatment of resistant hypertension (e.g., cardiologist, nephrologist)

Product Name:Tryvio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation the patient is receiving clinical benefit to Tryvio therapy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Tryvio will be used in combination with at least 3 antihypertensive medications from different classes at maximally tolerated doses</p>	

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/3/2025	Added NV Formulary

Tzield (teplizumab-mzwv)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-432190
<b>Guideline Name</b>	Tzield (teplizumab-mzwv)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Tzield	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of stage 2 type 1 diabetes</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient is at least 8 years of age</p>	

**AND**

**3** - Documentation of at least two positive pancreatic islet cell autoantibodies (e.g., glutamic acid decarboxylase 65 [GAD65], insulin autoantibody [IAA], insulinoma-associated antigen 2 autoantibody [IA-2A], zinc transporter 8 autoantibody [ZnT8A], islet cell autoantibody [ICA])

**AND**

**4** - Documentation of dysglycemia without overt hyperglycemia using an oral glucose tolerance test (an alternative method of diagnosis may be used if an oral glucose tolerance test is not available)

**AND**

**5** - Prescriber attests to the absence of acute Epstein-Barr virus (EBV) and CMV infection through laboratory or clinical evidence

**AND**

**6** - Prescriber has confirmed the absence of an active serious infection or chronic active infection, excluding localized skin infection

**AND**

**7** - The patient has received all age-appropriate vaccines, with live vaccines administered at least eight weeks before treatment, and inactivated vaccines and mRNA vaccines administered at least two weeks before treatment

**AND**

**8** - The patient is not pregnant or planning to become pregnant during the 14-day treatment course

**AND**

**9** - Prescribed by or in consultation with an adult or pediatric endocrinologist

**AND**

**10** - Request does NOT exceed 24 vials per 14-day course of therapy

**AND**

**11** - Request does NOT exceed one treatment course per lifetime

## 2 . Revision History

Date	Notes
10/27/2025	New program

Valchlor



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-509218
<b>Guideline Name</b>	Valchlor
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Valchlor
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of ONE of the following:

- Chronic or smoldering T-cell leukemia/lymphoma
- Primary cutaneous marginal zone or follicle center B-cell lymphoma
- Lymphomatoid papulosis (LyP) with extensive lesions
- Mycosis fungoides (MF)/Sezary syndrome (SS)

Product Name:Valchlor

Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of Langerhans Cell Histiocytosis (LCH)

**AND**

2 - Skin disease is unifocal and isolated

Product Name:Valchlor

Diagnosis	Primary Cutaneous Lymphomas, Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient does not show evidence of progressive disease while on Valchlor</p>	

Product Name:Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium</p>	

Product Name:Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Valchlor therapy</p>	

**2 . Revision History**

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

1/27/2026	Combined formularies. Reorganized WA policy to match CORE since no changes to clinical intent.
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Vanrafia



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434329
<b>Guideline Name</b>	Vanrafia
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Vanrafia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
	<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient is at risk of disease progression</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Medication is used to slow kidney function decline</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Medication is used to reduce proteinuria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>5</b> - Estimated glomerular filtration rate (eGFR) is greater than or equal to 30 mL/min/1.73 m<sup>2</sup></p> <p style="text-align: center;"><b>AND</b></p> <p><b>6</b> - Both of the following:</p> <p><b>6.1</b> Patient is on a maximized stable dose with ONE of the following prior to initiating therapy confirmed by claims history or submitted medical records:</p> <ul style="list-style-type: none"> <li>• Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)</li> <li>• Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)</li> </ul>

**AND**

**6.2** Use of endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer]) will be discontinued prior to initiating treatment

**AND**

**7** - One of the following:

**7.1** Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

**OR**

**7.2** History of contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify intolerance or contraindication)

**AND**

**8** - Prescribed by or in consultation with a nephrologist

Product Name:Vanrafia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Documentation of positive clinical response demonstrated by a reduction in proteinuria	

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
11/3/2025	Added NV Formulary

Vemlidy



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-434328
<b>Guideline Name</b>	Vemlidy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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## 1 . Criteria

Product Name:Vemlidy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

**Approval Criteria**

1 - Diagnosis of chronic hepatitis B infection

**AND**

2 - ONE of the following:

- Failure to entecavir (generic Baraclude) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to entecavir (generic Baraclude) (please specify contraindication or intolerance)
- Patient is not a suitable candidate for entecavir (generic Baraclude)

**AND**

3 - ONE of the following:

**3.1** Failure to tenofovir disoproxil fumarate (generic Viread) as confirmed by claims history or submission of medical records

**OR**

**3.2** History of contraindication or intolerance to tenofovir disoproxil fumarate (generic Viread) (please specify contraindication or intolerance)

**OR**

**3.3** Submission of medical records documenting an estimated glomerular filtration rate below 90 mL/min (milliliters/minute)

**OR**

**3.4** Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD (bone mineral density) T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from one of the following with

evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan [Provider must submit patient specific BMD T-scores]:

- Lumbar spine (at least two vertebral bodies)
- Hip (femoral neck, total hip)
- Radius (one-third radius site)

**OR**

**3.5** Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD T-score less than or equal to -2.5 based on BMD measurements from one of the following [Provider must submit patient specific BMD T-score]:

- Lumbar spine (at least two vertebral bodies)
- Hip (femoral neck, total hip)
- Radius (one-third radius site)

**OR**

**3.6** Submission of medical records documenting a prior low-trauma or non-traumatic fracture

**OR**

**3.7** Patient is less than 20 years of age

Product Name:Vemlidy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Vemlidy therapy</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient is not a suitable candidate for entecavir (generic Baraclude) or tenofovir disoproxil fumarate (generic Viread)

## 2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Verkazia (cyclosporine)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-398251
<b>Guideline Name</b>	Verkazia (cyclosporine)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Verkazia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is greater than or equal to 4 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has a diagnosis of vernal keratoconjunctivitis

**AND**

**3** - Prescriber attestation that disease severity is moderate to severe

**AND**

**4** - Patient has had a disease flare within the past 1 year

**AND**

**5** - Patient is NOT using another immunomodulator via the ophthalmic route (e.g., other formulations of cyclosporine, tacrolimus, pimecrolimus)

**AND**

**6** - Patient will NOT exceed a maximum daily dose of 4 vials

Product Name: Verkazia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet initial authorization criteria</p> <p><b>AND</b></p> <p><b>2</b> - Prescriber attestation that patient has had disease improvement and/or stabilization (e.g.,</p>	

improvement on corneal fluorescein staining [CFS], decrease in number of flares, improvement in symptoms)

**AND**

**3** - Patient has NOT experienced any treatment-restricting adverse effects (e.g., eye pain, infection)

## 2 . Revision History

Date	Notes
9/18/2025	New program.

Vimovo (naproxen-esomeprazole magnesium), Duexis (ibuprofen-famotidine)



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-422493
<b>Guideline Name</b>	Vimovo (naproxen-esomeprazole magnesium), Duexis (ibuprofen-famotidine)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name: Brand Vimovo, generic naproxen/esomeprazole, ibuprofen/famotidine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The requested medication is being used for an FDA (Food and Drug Administration) approved indication</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Documentation of one of the following risk factors for developing an NSAID (non-steroidal anti-inflammatory drug)-related ulcer:

- Previous history of a major gastrointestinal bleed, perforation, or obstruction
- Previous history of a peptic ulcer, hemorrhagic gastritis, hemorrhagic gastropathy, or erosive esophagitis
- Concomitant therapy for an anticoagulant or antiplatelet agent (including aspirin) or chronic oral corticosteroids
- The patient has had gastric bypass surgery (Roux-en-Y gastric bypass)

**AND**

**3** - The patient is intolerant to a COX-2 inhibitor or has had a gastric or duodenal ulcer while taking a COX-2 inhibitor

**AND**

**4** - The patient has experienced an NSAID-associated ulcer in the past while taking a single-entity PPI or prostaglandin agent concomitantly with an NSAID or the patient is intolerant to both PPIs and prostaglandin agents

**AND**

**5** - Documentation of an inadequate response or adverse reaction with concurrent therapy of an equivalent dose of the individual components

## 2 . Revision History

Date	Notes
10/21/2025	New guideline

Voquezna Dual and Triple Pak



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422544
<b>Guideline Name</b>	Voquezna Dual and Triple Pak
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Voquezna Dual Pak, Voquezna Triple Pak	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 18 years or age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has a confirmed diagnosis of Helicobacter pylori (H. pylori) infection</p>	

**AND**

**3** - Patient does NOT have hypersensitivity or cross-hypersensitivity to any component or drug class of the product (e.g., penicillins, cephalosporins, macrolides)

**AND**

**4** - Treatment will not be used concurrently with rilpivirine-containing products

**AND**

**5** - If the request is for Voquezna Triple Pak, both of the following:

**5.1** The patient does NOT have a history of hepatic dysfunction or cholestatic jaundice associated with prior use of clarithromycin

**AND**

**5.2** The patient does NOT have ventricular cardiac arrhythmia, prolongation of the QT interval, or proarrhythmic condition (e.g., uncorrected hypokalemia or hypomagnesemia)

**AND**

**6** - The patient has an adequate trial and failure of, or relevant medical reason for not using, PPI-based H. pylori treatment regimen

**AND**

**7** - Baseline renal and hepatic function laboratory tests have been obtained

## **2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/22/2025	New guideline

Vowst



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-434326
<b>Guideline Name</b>	Vowst
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Vowst	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

**Approval Criteria**

**1** - Diagnosis of recurrent *Clostridioides difficile* infection (rCDI) as defined by BOTH of the following:

**1.1** Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days

**AND**

**1.2** A positive stool test for *Clostridioides difficile* toxin

**AND**

**2** - Patient is 18 years of age or older

**AND**

**3** - Patient has had one or more recurrences of CDI following an initial episode of CDI

**AND**

**4** - Patient has completed at least 10 days of ONE of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst as confirmed by claims history or submission of medical records:

- Oral vancomycin
- Dificid (fidaxomicin)

**AND**

**5** - Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]

**AND**

**6** - Patient will drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst

**AND**

**7** - Prescribed by or in consultation with one of the following:

- Gastroenterologist
- Infectious disease specialist

## 2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Voxzogo (vosoritide)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-422488
<b>Guideline Name</b>	Voxzogo (vosoritide)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is less than 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has diagnosis of confirmed achondroplasia based on ONE of the following:

**2.1** Both of the following

**2.1.1** Clinical manifestations of achondroplasia (e.g. proximal shortening of arms, large head, narrow chest, short fingers) and radiographic (e.g., ilia and horizontal acetabula, narrow sacrosciatic notch, proximal radiolucency of the femurs, generalized metaphyseal abnormality, decreasing interpedicular distance caudally)

**AND**

**2.1.2** Radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia, and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphysis, and short and narrow chest)

**OR**

**2.2** Genetic testing with an identifiable mutation in the fibroblast growth factor receptor type 3 (FGFR3) gene

**AND**

**3** - Prescribed by or in consultation with endocrinologist, pediatric endocrinologist, clinical geneticist, or other specialist with advanced knowledge in treating achondroplasia

**AND**

**4** - Patient has open epiphyses

**AND**

**5** - Medication dosed per FDA-label based on patient's actual body weight

**AND**

**6** - Prescriber attestation that patient body weight, growth, and physical development will be monitored and assessed every three to six months

**AND**

**7** - Patient has not had (within the previous 18 months) nor will they receive limb lengthening surgery

Product Name:Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet initial authorization criteria</p> <p><b>AND</b></p> <p><b>2</b> - Documentation of positive clinical response to therapy as demonstrated by improvement in annualized growth velocity compared to pre-treatment baseline</p>	

**2 . Revision History**

Date	Notes
10/20/2025	1/1/2026 Implementation

Voydeya (danicopan)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-421235
<b>Guideline Name</b>	Voydeya (danicopan)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Voydeya	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry testing</p>	

**AND**

**2** - Patient is at least 18 years old

**AND**

**3** - Patient has received a stable dose of C5 inhibitor therapy (ravulizumab-cwvz [Ultomiris] or eculizumab [Soliris]) for at least 6 months prior to starting Voydeya

**AND**

**4** - Voydeya will be used as add-on therapy to eculizumab (Soliris) or ravulizumab-cwvz (Ultomiris)

**AND**

**5** - Patient has clinically significant extravascular hemolysis (EVH) while on Soliris or Ultomiris as evidenced by both of the following:

- Hb 9.5 g/dL or less
- Absolute reticulocyte count at least 120 x 10<sup>9</sup>/L

**AND**

**6** - Prescribed by or in consultation with Hematologist

**AND**

**7** - Patient has documented vaccinations for Neisseria meningitidis (N. meningitidis) and Streptococcus pneumoniae (S. pneumoniae) at least 2 weeks prior to initiating therapy

**AND**

**8** - Patient does NOT have any of the following:

- Severe hepatic impairment (Child-Pugh class C)
- Unresolved serious infection caused by encapsulated bacteria (including N. meningitides, S. pneumoniae, or Haemophilus influenzae type b [HIB])

Product Name:Voydeya	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Voydeya being used as add-on therapy to eculizumab (Soliris) or ravulizumab-cwvz (Ultomiris)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by or in consultation with Hematologist</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Patient has demonstrated positive response to therapy (e.g., decreased requirement of RBC transfusions, Hb stabilization or improvement LDH reduction, symptom improvement or stabilization, reduction in thrombotic events)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>4</b> - Patient does not have any treatment restricting adverse effects (e.g., encapsulated bacterial infection, clinically significant or symptomatic hepatic enzyme elevations)</p>	

**2 . Revision History**

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
10/13/2025	New program

Vuity (pilocarpine)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-392219
<b>Guideline Name</b>	Vuity (pilocarpine)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Brand Vuity, generic pilocarpine 1.25% ophth soln	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient has a diagnosis of presbyopia</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Prescribed by or in consultation with an ophthalmologist or optometrist

**AND**

**3** - Patient is unable to use corrective lenses (e.g., eyeglasses or contact lenses) confirmed by medical records (e.g., chart notes)

**AND**

**4** - The requested medication will NOT be prescribed concurrently with any ophthalmic pilocarpine formulations

Product Name: Brand Vuity, generic pilocarpine 1.25% ophth soln	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Documentation of positive clinical response to therapy (e.g., improvement in near vision in low light conditions without loss of distance vision)</p> <p><b>AND</b></p> <p><b>2</b> - Prescribed by or in consultation with an ophthalmologist or optometrist</p>	

**2 . Revision History**

Date	Notes
9/12/2025	New program.

Vyalev



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434325
<b>Guideline Name</b>	Vyalev
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Vyalev
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Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of advanced Parkinson's disease</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has inadequately controlled motor fluctuations despite being treated with optimized oral therapies (e.g. levodopa)</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by or in consultation with a neurologist</p>	

Product Name:Vyalev	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Vyalev therapy demonstrated by an increase in “on” time without troublesome dyskinesia</p>	

**2 . Revision History**

Date	Notes
11/3/2025	Added NV Formulary



Vyjuvek (beremagene geperpavec-svdt)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-398228
<b>Guideline Name</b>	Vyjuvek (beremagene geperpavec-svdt)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Vyjuvek	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is 6 months of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has NOT received a skin graft within the past 3 months

**AND**

**3** - Patient has a genetically confirmed diagnosis of dystrophic epidermolysis bullosa (DEB) with mutation in the collagen type VII alpha 1 chain (COL7A1) gene

**AND**

**4** - Prescribed by or in consultation with ONE of the following:

- Pediatric dermatologist
- Other specialist with advanced knowledge of treating DEB

**AND**

**5** - Patient has cutaneous wound(s) which are clean with adequate granulation tissue, excellent vascularization, and do not appear infected

Product Name:Vyjuvek	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Patient has NOT experienced any unacceptable toxicity from the drug (e.g., severe medication reaction resulting in discontinuation of therapy)</p>	

**AND**

**3** - Patient has disease response as defined by improvement (healing) of treated wound(s)

**AND**

**4** - Patient requires continued treatment for new and/or existing open wounds

## **2 . Revision History**

Date	Notes
9/17/2025	New program.

Vykat XR



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434324
<b>Guideline Name</b>	Vykat XR
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Washington (ACUWA, ACUWAAHE, ACUWAC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Vykat XR	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of hyperphagia associated with Prader-Willi Syndrome</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prader-Willi Syndrome is confirmed by genetic testing</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient is at least 4 years of age or older</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by or in consultation with an endocrinologist, geneticist, or a specialist with knowledge in the treatment of Prader-Willi syndrome</p>	

Product Name:Vykat XR	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive clinical response to Vykat XR therapy</p>	

## 2 . Revision History

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

11/3/2025	Added NV Formulary
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Vyndaqel and Vyndamax



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-435236
<b>Guideline Name</b>	Vyndaqel and Vyndamax
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Vyndaqel, Vyndamax	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - ONE of the following:</b></p> <p><b>2.1 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>2.3 ALL of the following</b></p> <p><b>2.3.1 Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2.3.3 Absence of light chain amyloidosis</b></p> <p style="text-align: center;"><b>AND</b></p>	

**3** - Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure

**AND**

**4** - Physician attests that the patient has an N-terminal pro-B-type natriuretic peptide (NT-proBNP) level that, when combined with signs and symptoms, is considered definitive for a diagnosis of ATTR-CM

**AND**

**5** - ONE of the following:

- History of heart failure, with at least one prior hospitalization for heart failure
- Presence of clinical signs and symptoms of heart failure (e.g., dyspnea, edema)

**AND**

**6** - One of the following:

- Failure to Attriby as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Attriby (please specify intolerance or contraindication)

**AND**

**7** - Prescribed by, or in consultation, with a cardiologist

**AND**

**8** - Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Attriby (acoramadis), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]

Notes

\*May require prior authorization and notification

Product Name:Vyndaqel, Vyndamax

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation that the patient has experienced a positive clinical response to Vyndaqel or Vyndamax (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Prescribed by or in consultation with a cardiologist</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Attruby (acoramadis), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]</p>	

## 2 . Revision History

Date	Notes
11/3/2025	Added a step through Attruby. Added NV formulary.

Wainua (eplontersen)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-429197
<b>Guideline Name</b>	Wainua (eplontersen)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Wainua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is greater than or equal to 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Patient has a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis confirmed by testing (e.g., genetic testing, biopsy)

**AND**

**3** - Prescribed by, or in consultation with, ONE of the following:

- Cardiologist
- Geneticist
- Neurologist
- Other specialist with advanced knowledge in treating hereditary transthyretin-mediated amyloidosis

**AND**

**4** - Patient has clinical manifestations of polyneuropathy

**AND**

**5** - Medication will NOT be used in combination with inotersen (Tegsedi), tafamidis (Vyndamax), tafamidis meglumine (Vyndaqel), patisiran (Onpattro), or vutrisiran (Amvuttra)

**AND**

**6** - Patient does NOT have any of the following conditions:

- Severe renal impairment or end-stage renal disease
- Moderate or severe hepatic impairment
- Prior liver transplant

**AND**

**7** - Prescriber will supplement vitamin A at the recommended daily allowance as appropriate and refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness, dry eyes) occur

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Product Name:Wainua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient continues to meet initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient has demonstrated a clinical benefit based on improvement in clinical manifestations of polyneuropathy from baseline</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe ocular symptoms related to vitamin A deficiency)</p>	

**2 . Revision History**

Date	Notes
10/27/2025	New program.

Winrevair



## Prior Authorization Guideline

<b>Guideline ID</b>	GL-391208
<b>Guideline Name</b>	Winrevair
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

### Guideline Note:

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Winrevair	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is 18 years of age or older</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Prescribed by, or in consultation with, a pulmonologist or cardiologist

**AND**

**3** - Diagnosis of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1

**AND**

**4** - Submission of right heart catheterization results confirming diagnosis

**AND**

**5** - The patient's WHO functional class is II or greater

**AND**

**6** - The patient has been stable on background PAH therapy for greater than or equal to 90 days and will continue background PAH therapy during treatment with Winrevair, unless contraindicated \*

**AND**

**7** - The patient does not have a baseline platelet count less than  $50 \times 10^9/L$

**AND**

**8** - The prescriber attests that hemoglobin (Hgb) and platelet levels will be monitored per package insert (e.g., before each dose for at least the first five doses)

**AND**

**9** - If the patient is a female of reproductive potential both of the following:

- They have a negative pregnancy test prior to starting therapy
- They have been counseled on use of effective contraception during treatment

**AND**

**10** - Winrevair will be dosed per FDA-label based on patient's weight

Notes

\*Please note: Background therapy refers to combination therapy consisting of drugs from greater than or equal to 2 of the following drug classes: endothelin receptor antagonists (ERA), phosphodiesterase type 5 (PDE5) inhibitor (PDE5i), soluble guanylate cyclase stimulator, and/or prostacyclin analogue or receptor agonist

Product Name: Winrevair

Approval Length 12 month(s)

Therapy Stage Reauthorization

Guideline Type Prior Authorization

**Approval Criteria**

**1** - Prescribed by, or in consultation with, a pulmonologist, or cardiologist

**AND**

**2** - Winrevair will be dosed per FDA-label based on patient's weight

**AND**

**3** - Documentation of positive clinical response to therapy

**AND**

**4** - The patient continues on background PAH therapy during treatment with Winrevair, unless contraindicated \*

Notes	*Please note: Background therapy refers to combination therapy consisting of drugs from greater than or equal to 2 of the following drug classes: endothelin receptor antagonists (ERA), phosphodiesterase type 5 (PDE5) inhibitor (PDE5i), soluble guanylate cyclase stimulator, and/or prostacyclin analogue or receptor agonist
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## 2 . Revision History

Date	Notes
9/10/2025	1/1/2026 Implementation

Xdemvy



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-505195
<b>Guideline Name</b>	Xdemvy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Michigan (ACUMI)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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**1 . Criteria**

Product Name:Xdemvy
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Approval Length	6 Week(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Demodex blepharitis</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Patient demonstrates ONE of the following signs of Demodex infestation:</p> <ul style="list-style-type: none"> <li>• Cylindrical cuff at the root of the eyelashes</li> <li>• Lid margin erythema</li> <li>• Eyelash anomalies (e.g., eyelash misdirection, eyelash loss)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>3 - Patient demonstrates TWO of the following symptoms of Demodex infestation:</p> <ul style="list-style-type: none"> <li>• Itching/Burning</li> <li>• Foreign body sensation</li> <li>• Crusting/matted lashes</li> <li>• Blurry vision</li> <li>• Discomfort/irritation</li> <li>• Tearing/lacrimation</li> <li>• Dryness</li> <li>• Purulence/discharge</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p>4 - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil)</p> <p style="text-align: center;"><b>AND</b></p> <p>5 - Prescribed by or in consultation with ONE of the following:</p> <ul style="list-style-type: none"> <li>• Ophthalmologist</li> </ul>	

- Optometrist

## 2 . Revision History

Date	Notes
1/22/2026	Combined formularies. No changes to clinical criteria.

Xiaflex



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-482199
<b>Guideline Name</b>	Xiaflex
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Xiaflex	
Diagnosis	Dupuytren's Contracture
Approval Length	4 Week(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is at least 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - The patient has a confirmed diagnosis of Dupuytren’s contracture with a palpable cord

**AND**

**3** - The patient has not received surgical treatment (e.g., fasciotomy) on the selected primary joint within the last 90 days

**AND**

**4** - Documentation that the flexion deformity is causing functional limitations

**AND**

**5** - Treatment is administered no sooner than a four-week intervals

**AND**

**6** - The patient has not had 3 cycles in total

Product Name:Xiaflex	
Diagnosis	Peyronie's Disease (PD)
Approval Length	6 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient is at least 18 years of age</p> <p><b>AND</b></p>	

**2** - The patient has a confirmed diagnosis of Peyronie’s disease (PD) with a palpable plaque

**AND**

**3** - The patient has curvature deformity of at least 30 degrees and

**AND**

**4** - Xiaflex is not being used for sexual or erectile dysfunction associated with PD

**AND**

**5** - Must be used in conjunction with penile modeling procedure

**AND**

**6** - Treatment is administered no sooner than 6-week intervals

**AND**

**7** - The patient has not had 4 cycles in total

<b>Product Name:</b> Xiaflex	
<b>Diagnosis</b>	Peyronie's Disease (PD)
<b>Approval Length</b>	6 Week(s)
<b>Therapy Stage</b>	Reauthorization
<b>Guideline Type</b>	Prior Authorization
<b>Approval Criteria</b>	
<b>1</b> - The patient continues to meet the initial authorization criteria	

**AND**

**2** - Curvature deformity remains greater than 15 degrees (curvature less than 15 degrees does not warrant subsequent treatment cycle)

Xolremdi



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-395221
<b>Guideline Name</b>	Xolremdi
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Xolremdi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than or equal to 12 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome with genotype-confirmed CXCR4 variant

**AND**

**3** - Prescribed by, or in consultation with, a geneticist, immunologist, or other specialist with advance knowledge in treating WHIM syndrome

**AND**

**4** - Confirmed absolute neutrophil count (ANC) less than or equal to 400 cells/ $\mu$ L (or total white blood cell (WBC) count less than or equal to 400 cells/ $\mu$ L if ANC is below lower limit of detection)

**AND**

**5** - Prescriber attestation to assess QTc at baseline and to monitor QTc periodically during treatment for patients with risk factors for QTc prolongation

**AND**

**6** - The patient is not taking any of the following:

- Another CXCR4 antagonist (e.g., plerixafor [Mozobil])
- Any medication that is highly dependent on cytochrome P450 (CYP) 2D6 for clearance (e.g., amitriptyline, fluoxetine)
- A strong CYP3A4 inducer (e.g., rifampin, phenytoin)

**AND**

**7** - If the request is for a female of reproductive potential BOTH of the following:

- The patient has a confirmed negative pregnancy test prior to initiation
- The patient attests to use effective contraception during treatment and for three weeks after the last dose

**AND**

**8** - Xolremdi will be dosed per FDA label based on patient's body weight with dose when used concomitantly with a strong CYP3A4 inhibitor

Product Name:Xolremdi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient continues to meet the initial authorization criteria</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Positive response to therapy (e.g., improvement in ANC and/or absolute lymphocyte counts [ALC], reduction in infections)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - The patient has not experienced any treatment restricting adverse effects (e.g., significant QTc prolongation)</p>	

**2 . Revision History**

Date	Notes
9/17/2025	1/1/2026 Implementation

Yorvipath (palopegteriparatide)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-504204
<b>Guideline Name</b>	Yorvipath (palopegteriparatide)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/1/2026
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### 1 . Criteria

Product Name:Yorvipath	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient is greater than 18 years of age</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Diagnosis of hypoparathyroidism that is not acute post-surgical

**AND**

**3** - Within the previous two weeks the patient has both of the following:

- Serum 25(OH) vitamin D within the normal range
- Albumin-corrected serum calcium greater than or equal to 7.8 mg/dL (milligrams per deciliter)

**AND**

**4** - Prescriber attestation that patient’s disease cannot be adequately controlled on maximally tolerated active vitamin D (calcitriol) and elemental calcium

**AND**

**5** - Medication is prescribed by, or in consultation with, an endocrinologist or nephrologist

**AND**

**6** - The request does not exceed two pens/28 days for a max dose of 30 mcg daily

Product Name:Yorvipath	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Documentation of positive response to therapy</p>	

**AND**

**2** - Medication is prescribed by, or in consultation with, an endocrinologist or nephrologist

## **2 . Revision History**

Date	Notes
1/16/2026	Clarified $\geq$ and mg/dL. Added prescriber requirement to initial and reauth. Added patient can't be controlled on vitamin D and calcium to initial auth. Removed initial auth requirement for reauth.

Zeposia (ozanimod)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-512264
<b>Guideline Name</b>	Zeposia (ozanimod)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	2/4/2026
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### 1 . Criteria

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - The patient has as a diagnosis of moderately to severely active UC (ulcerative colitis)</p> <p style="text-align: center;"><b>AND</b></p>	

**2** - Prescribed by, or in consultation with, a gastroenterologist

**AND**

**3** - Inadequate response after a 90-day trial of one of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylates (e.g., mesalamine, balsalazide, olsalazine)
- Sulfasalazine
- Azathioprine
- Corticosteroids (e.g., budesonide, high dose steroids, 40-60 mg of prednisone daily)

**AND**

**4** - The patient has tried and failed two preferred immunomodulator therapies indicated for moderately to severely active UC\*

Notes	*PDL link: <a href="https://myhpnmedicaid.com/member/pharmacy-benefits">https://myhpnmedicaid.com/member/pharmacy-benefits</a>
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Product Name: Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - One of the following:</p> <p><b>2.1</b> The requested medication is being used for continuation of therapy</p>	

**OR**

**2.2** The patient has had failure after a trial of at least four weeks, contraindication, or intolerance to at least one of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Tecfidera (dimethyl fumarate)

**AND**

**3** - Prescribed by, or in consultation with, a neurologist

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - The patient has documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression)</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Prescribed by, or in consultation with, a neurologist</p>	

## 2 . Revision History

Date	Notes
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Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

2/4/2026	Updated PDL Link
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Zilbrysq



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434312
<b>Guideline Name</b>	Zilbrysq
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Indiana (ACUIN)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Zilbrysq	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming ALL of the following:</p> <p>1.1 Diagnosis of generalized myasthenia gravis (gMG)</p> <p style="text-align: center;"><b>AND</b></p> <p>1.2 Positive serologic test for anti-AChR antibodies</p> <p style="text-align: center;"><b>AND</b></p> <p>1.3 Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>1.4 Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - ONE of the following:</p> <p>2.1 History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) as confirmed by claims history or submission of medical records</p> <p style="text-align: center;"><b>OR</b></p> <p>2.2 Patient has a history of failure of at least one immunosuppressive therapy (as confirmed by claims history or submission of medical records) and has required four or more courses of</p>	

plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control

**OR**

**2.3** Contraindication or intolerance to at least two immunosuppressive agents (please specify contraindication or intolerance)

**AND**

**3** - Patient is not receiving Zilbrysq in combination with another complement inhibitor [e.g., Soliris (eculizumab), Ultomiris (ravulizumab-cwvz)] or a neonatal Fc receptor blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]

**AND**

**4** - Prescribed by, or in consultation with, a neurologist

Product Name:Zilbrysq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1</b> - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by at least ALL of the following:</p> <p><b>1.1</b> Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline</p> <p><b>AND</b></p> <p><b>1.2</b> Reduction in signs and symptoms of myasthenia gravis</p>	

**AND**

**1.3** Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Zilbrysq\*

**AND**

**2** - Patient is not receiving Zilbrysq in combination with another complement inhibitor [e.g., Soliris (eculizumab), Ultomiris (ravulizumab-cwvz)] or a neonatal Fc receptor blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]

**AND**

**3** - Prescribed by, or in consultation with, a neurologist

Notes	*Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Zilbrysq therapy will be considered as treatment failure
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## 2 . Revision History

Date	Notes
11/3/2025	Added NV formulary.

Zokinvy



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-434311
<b>Guideline Name</b>	Zokinvy
<b>Formulary</b>	<ul style="list-style-type: none"> <li>• Medicaid - Community &amp; State Colorado (ACUCO, ACUCOC)</li> <li>• Medicaid - Community &amp; State Hawaii (ACUHI, ACUHIEC)</li> <li>• Medicaid - Community &amp; State Maryland (ACUMD)</li> <li>• Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> <li>• Medicaid - Community &amp; State New Jersey (PSI2300)</li> <li>• Medicaid - Community &amp; State New York EPP (ACUNYEPP)</li> <li>• Medicaid - Community &amp; State New York (ACUNY, ACUNYM)</li> <li>• Medicaid - Community &amp; State Pennsylvania CHIP (ACUPAC)</li> <li>• Medicaid - Community &amp; State Rhode Island (ACURI)</li> <li>• Medicaid - Community &amp; State Arizona (ACUAZ, ACUAZEC)</li> <li>• Medicaid - Community &amp; State Virginia (ACUVA, ACUVAC, ACUVAEC)</li> <li>• Medicaid - Community &amp; State Pennsylvania (ACUPA)</li> <li>• Medicaid - Community &amp; State Nebraska (ACUNE)</li> <li>• Medicaid - Community &amp; State New Mexico (ACUNM)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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**1 . Criteria**

Product Name:Zokinvy	
Diagnosis	Hutchinson-Gilford Progeria Syndrome

Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of Hutchinson-Gilford Progeria Syndrome</p>	

Product Name:Zokinvy	
Diagnosis	Progeroid Laminopathies
Approval Length	12 month(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of processing deficient Progeroid laminopathy</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Documentation of ONE of the following:</p> <ul style="list-style-type: none"> <li>• Heterozygous LMNA (gene) mutation with progerin-like protein accumulation</li> <li>• Homozygous or compound heterozygous ZMPSTE24 (gene) mutations</li> </ul>	

**2 . Revision History**

Date	Notes
11/3/2025	Added NV formulary

Zynteglo (betibeglogene autotemcel)



### Prior Authorization Guideline

<b>Guideline ID</b>	GL-395187
<b>Guideline Name</b>	Zynteglo (betibeglogene autotemcel)
<b>Formulary</b>	<ul style="list-style-type: none"> <li>Medicaid - Health Plan of Nevada Medicaid (ACUNV)</li> </ul>

**Guideline Note:**

Effective Date:	1/1/2026
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### 1 . Criteria

Product Name:Zynteglo	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Patient is greater than or equal to 4 years of age</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Diagnosis of beta-thalassemia confirmed with genetic testing</p>	

**AND**

**3** - Prescribed by, or in consultation with, a hematologist

**AND**

**4** - Prescriber attests that the patient is a candidate for autologous hematopoietic stem-cell transplant (HSCT)

**AND**

**5** - The patient has not previously received an allogeneic transplant

**AND**

**6** - The patient has not previously received other gene therapies (e.g., Casgevy)

**AND**

**7** - The patient has transfusion-dependent disease defined as ONE of the following:

- History of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs)
- Greater than or equal to 8 transfusions of pRBCs per year in the previous two years

**AND**

**8** - The patient has been screened for HBV, HCV, human T-lymphotropic virus 1 and 2 (HTLV-1/HTLV-2), and HIV in accordance with clinical guidelines prior to collection of cells (leukapheresis)

**AND**

**9** - If the patient requires anti-retrovirals for HIV prophylaxis, BOTH of the following:

- The patient has not used prophylactic HIV anti-retroviral medication or hydroxyurea within 30 days prior to mobilization (or for the expected duration for elimination of those medications) and until all cycles of apheresis are completed
- Confirmation of a negative test for HIV before beginning mobilization

**AND**

**10** - Iron chelation therapy has been discontinued for at least seven days prior to initiating myeloblastic conditioning therapy and myelosuppressive iron chelators will be avoided for six months post-treatment

**AND**

**11** - The patient does not have any of the following:

- Severely elevated iron in the heart (e.g., patients with cardiac T2 <10 msec by MRI)
- Advanced liver disease
- MRI of the liver with results demonstrating liver iron content  $\geq 15$  mg/g (unless biopsy confirms absence of advanced disease)

**AND**

**12** - The patient has been counseled and verbalized understanding that hematologic malignancies may develop in individuals treated with Zynteglo and lifelong monitoring is warranted

**AND**

**13** - Prescriber attestation that all necessary preparations prior to Zynteglo administration will be followed per package insert (including scheduled transfusions to target required Hb levels)

**AND**

**14** - The patient has not previously received one treatment course of Zynteglo in their lifetime

## 2 . Revision History

Health Plan of Nevada Medicaid – Clinical Pharmacy Guidelines

Date	Notes
9/10/2025	1/1/2026 implementation